Reset Form

HOME AND COMMUNITY CARE SUPPORT SERVICES
South East

COVID-19 Remote Monitoring Program Referral Form

Patient Information

Please fax to: **1-866-839-7299**

LAST NAME	FIRST NAME	DATE OF BIRTH (DD MM YYYY)
HCN		GENDER
ADDRESS		CITY
POSTAL CODE	PRIMARY PHONE NUMBER	
FIRST LANGUAGE	SECOND LANGUAGE	POTENTIAL DISCHARGE DATE (DD MM YYYY)
EMAIL ADDRESS	CELL PHONE NUMBER	EMERGENCY CONTACT

Patients enrolled in the COVID-19 Remote Monitoring Program use an app on their smartphone to report their symptoms to their nurse. Please ensure that mobile phone number is clearly indicated:

MOBILE/CELL NUMBER: _____ ☐ Patient does not own a smart device

Eligibility for Referral (Patient must meet ALL the following criteria)

- ☐ COVID-19 Positive, OR
- ☐ HIGHLY PROBABLE, e.g.) direct contact with known COVID-19 case
- ☐ Patient consents to participate in remote monitoring program
- ☐ Patient is able to communicate with nurse in English

Risk Factors

- ☐ Diabetes with complications
- ☐ Congestive heart failure
- ☐ Chronic lung disease (i.e. COPD, emphysema), or moderate to severe asthma
- ☐ Weakened immune system
- ☐ Dialysis
- ☐ Cirrhosis of the liver
- ☐ Neurological conditions that weaken ability to cough
- ☐ Pregnancy
- ☐ Extreme obesity
- ☐ >= 65 years old
- ☐ On Home 02, L/min: _____

Referrer Information

NAME AND CPSO #
POSITION
EXTENSION
LOCATION OF REFERRAL
OHIP BILLING #

Primary Care Provider's Information

NAME
PHONE NUMBER
FAX NUMBER

Additional Information (if relevant)

Ontario