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Ontario

Home and Community Care Support Services North West
961 Alloy Drive
Thunder Bay, ON P7B 5Z8

Services de soutien à domicile et en milieu communautaire Nord-Ouest
961, promenade, Alloy
Thunder Bay, ON P7B 5Z8

COPD & Heart Failure Telehomecare Referral Form

Please fax to: 807.767.6968 or 1.855.272.6025

If required, Telehomecare staff will fax the referral form to the Primary Care Provider to verify and/or add any relevant information.

PATIENT INFORMATION

Referral Date (DD a a a YYYY) _____

LAST NAME	FIRST NAME	DATE OF BIRTH (DD a a a YYYY)
HEALTH CARD NUMBER (OHIP)	VC	GENDER MALE ☐ FEMALE ☐
ADDRESS	CITY	
POSTAL CODE	PRIMARY PHONE NUMBER	
FIRST LANGUAGE	SECOND LANGUAGE	

GENERAL ELIGIBILITY

- ☐ Health care provider feels the patient will benefit from Tele homecare. (This would require the patient or caregiver being able to operate simple equipment.)
- ☐ Patient lives in a residential setting with cellular service
- ☐ Patient or family caregiver is able to provide informed consent to participate

MAIN DIAGNOSIS FOR MONITORING

☐ **Congestive Heart Failure (CHF)** ☐ **Chronic Obstructive Pulmonary Disease (COPD)**

HOME AND COMMUNITY CARE SUPPORT SERVICES NORTH WEST TELEHOMECARE

- ☐ Patient has an established diagnosis of **CHF** and **(NYHA) Class 1 or Class 2 (able to self manage)**
- ☐ Patient has an established diagnosis of **COPD with** mild to moderate COPD **without** frequent exacerbations **(able to self manage)**

CO-MORBIDITIES

- ☐ **Diabetes**
- ☐ **COPD**
- ☐ **CHF**
- ☐ **Depression**
- ☐ **Hypertension**
- ☐ **Anxiety**
- ☐ **Other_____**

TBRHSC INTERNAL MEDICINE CLINIC TELEHOMECARE

- ☐ Patient has an established diagnosis of **CHF** and **(NYHA) Class 3 or Class 4** with at least 1- 2 hospital admissions or ER visits in the past 6-12 months **(requires medical intervention)**
- ☐ Patient has an established diagnosis of **COPD with** severe to very severe symptoms and/or 1 or more hospital admissions within the last year due to exacerbations **(requires medical intervention)**

REFERRER'S INFORMATION ☐ I would like to receive patient reports

NAME	ORGANIZATION	CPSO/CNO NUMBER
POSITION	OTHER DESCRIPTION	NAME/ADDRESS STAMP
ADDRESS		
PHONE NUMBER	FAX PHONE NUMBER	
A complete and current medication list would be helpful. Please attach any additional information (consultant notes, lab or imaging reports, recent spirometry results if done, recent ECHO if done, patient-specific health care challenges) if available.		

MEDICATIONS

☐ Current medication list attached (or can be recorded below).

☐ Contact pharmacy for medication list

LIST MEDICATIONS AND/OR ADDITIONAL INSTRUCTIONS OR NOTES

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