

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 MM YYYY): ____/____/____

LAST NAME	FIRST NAME	DATE OF BIRTH (DDMMYYYY)
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 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)**

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)**

CO-MORBIDITIES

- Diabetes**
- COPD**
- CHF**
- Depression**
- Hypertension**
- Anxiety**
- Other** _____

Note: The information contained in this form is confidential. It contains personal health information that is subject to the provisions of the 'Personal Health Information Protection Act, 2004'. This form and its contents should not be distributed, copied or disclosed to any unauthorized persons. If you have accessed this form in error, please contact the owner or sender immediately. V 4.0

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		
<p>A complete and current medication list would be helpful.</p> <p>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.</p>			

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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