

Telehomecare – Remote Monitoring Program Referral Form

Please fax to: 613-745-8243 or 1-855-450-8569

Referral for:

Remote Monitoring COPD Remote Monitoring Heart Failure Remote Monitoring COVID-19
Enhanced In-Home Remote Monitoring COPD Pilot with Hôpital Montfort Enhanced In Home Remote Monitoring Heart Failure Pilot with Hôpital Montfort Enhanced In-Home Remote Monitoring ALC Pilot with Hôpital Montfort *Enhanced program includes: RRN visits, Remote Monitoring, Community Paramedics, Hospital partnership MANDATORY For Enhanced In Home Remote Monitoring – Hôpital Montfort has faxed Referral to Ottawa Community Paramedics
***For nursing, PSS, OT, PT, dietician, SW or SLP, use the Home and Community Care Support Services - Champlain Medical Referral Form or the Infusion Therapy/Venous Access Referral Form ***

Patient Information

Referral Date:

Last Name		First Name		Date of Birth (DD MM YYYY)	
Health Card Number (OHIP)			VC	Gender	
Address			City		
Postal Code	Primary Phone Number		Mobile Number		
First Language			Second Language		

Eligibility for Telehomecare Services

Patient has an established diagnosis (for COVID -19, probable cases accepted)

Frequent ED visits/ hospital admissions/ visits to primary care provider and/or difficulty managing symptoms of disease (i.e., anxiety, shortness of breath, edema).

Health care provider feels patient will benefit from Telehomecare.

Patient or caregiver is able to provide informed consent to participate

Main Diagnosis for Monitoring	COPD	Heart Failure	COVID-19
Co-morbidities			
Diabetes	COPD	Heart Failure	Depression
Anxiety	Arthritis	Osteoporosis	Cancer
			Hypertension
			Other

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Physiologic Parameters the following patient vitals will be monitored:

Heart Failure Default	Systolic BP	Diastolic BP	Oxygen Sat.	Pulse	Weight (lbs.)
High	150	100	100	100	+2 lbs / day
Low	90	60	92	50	-5 lbs / day

COPD Default	Systolic BP	Diastolic BP	Oxygen Sat	Pulse	Weight (lbs.)
High	150	100	100	100	+5 lbs / week
Low	90	60	88	50	-5 lbs / week

The default parameters ABOVE will be used unless specific patient parameters are provided BELOW:

Patient	Systolic BP	Diastolic BP	Oxygen Sat	Pulse	Weight (lbs.)
High					
Low					

Referrer's Information I would like to receive patient reports Yes No

Name	Position	CPSO/CNO Number
Organization	Name / Address Stamp	
Address		
Phone Number		

Primary Care Provider's Information Same as above

Is PCP interested in receiving patient reports? Yes No N/A

Name	Position	CPSO/CNO Number
Organization	Name/Address Stamp	
Address		
Phone Number		

If available, please attach any additional information (consultant notes, lab or imaging reports, patient-specific health care challenges).

Medications

Current medication list attached (or recorded below).

Contact pharmacy for medication list

List medications and/or additional instructions or notes

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