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SOUTHLAKE REGIONAL HEALTH CENTRE

COPD & Heart Failure Telehomecare Referral Form

Please fax referral form(s) to: 905-830-5980

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

PATIENT INFORMATION

LAST NAME	FIRST NAME	DATE OF BIRTH (DD-MM-YYYY)

HEALTH CARD NUMBER (OHIP)	VC	GENDER
		◯ MALE ◯ FEMALE

ADDRESS	CITY

POSTAL CODE	PRIMARY PHONE NUMBER

FIRST LANGUAGE	SECOND LANGUAGE

ELIGIBILITY FOR TELEHOMECARE SERVICES

- ☐ Patient has an established diagnosis of Heart Failure or COPD (with or without co-morbid conditions).
- ☐ Patient lives in a residential setting with an active land line (internet or analog phone line).
- ☐ Health care provider feels the patient will be capable of using simple in-home monitoring equipment.
- ☐ Patient or family caregiver is able to provide informed consent to participate.

MAIN DIAGNOSIS FOR MONITORING

☐ COPD or ☐ Heart Failure

CO-MORBIDITIES

☐ Diabetes ☐ COPD ☐ Heart Failure ☐ Depression ☐ Hypertension

☐ Anxiety ☐ Arthritis ☐ Osteoporosis ☐ Cancer ☐ Other _____

REFERRER'S INFORMATION

NAME	ORGANIZATION	NAME/ADDRESS STAMP

POSITION	OTHER DESCRIPTION

ADDRESS

PHONE NUMBER	FAX PHONE NUMBER

PRIMARY CARE PROVIDER'S INFORMATION

☐ Same as above

NAME

ADDRESS

A complete and current medication list would be helpful. Please attach any additional information (consultant notes, lab or imaging reports, patient-specific health care challenges) if available.

REFERRER'S SIGNATURE _____ DATE (DD-MM-YYYY) / /

PRIMARY CARE PROVIDER'S SIGNATURE _____ DATE (DD-MM-YYYY) / /

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PHYSIOLOGIC PARAMETERS

The following patient vitals will be monitored:

CHF 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
High				
Low				

MEDICATIONS

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

☐ Contact pharmacy for medication list

LIST MEDICATIONS AND/OR ADDITIONAL INSTRUCTIONS OR NOTES