Ontario Health atHome

250 Dundas Street West, Suite 305, Toronto, ON M5T 2Z5 Tel: 416-506-9888 | 1-866-243-0061
www.ontariohealthathome.ca

# REFERRAL FORM FOR Ontario Health atHome

***FOR RM&R DOWNTIME USE ONLY***

PLEASE FAX COMPLETED REFERRAL FORM TO Ontario Health atHome TORONTO Office Location 416-217-1168

* PLEASE PRINT CLEARLY *

## PATIENT INFORMATION

**LAST NAME:** _____ **FIRST NAME:** _____

**HEALTH CARD #:** _____**VC:**_____ **DATE OF BIRTH: DD** _____ **MM** _____ **YYYY**_____

**ADDRESS:** _____ **APT#:**_____**ENTRY CODE:** _____

**CITY:**_____ **PROVINCE:** _____ **POSTAL CODE:**_____

**PRIMARY TELEPHONE #:** (_____)_____**ALTERNATE:** (_____)_____

**PREFERRED LANGUAGE:** _____

## **PATIENT'S** PRIMARY CONTACT INFORMATION

**LAST NAME:** _____ **FIRST NAME:** _____

**RELATIONSHIP TO PATIENT:**_____ **PRIMARY TELEPHONE #:**(_____)_____

**ALTERNATE:** (_____)_____ **PREFERRED LANGUAGE:** _____

**Reason for Ontario Health atHome Service Referral:**

**Has the patient fallen within the last 30 days?:** Yes ☐ No ☐
**Was the patient in hospital within the last 30 days?:** **Yes** ☐ **No** ☐
**Is the Patient/POA/SDM aware of this referral:** **Yes** ☐ **No** ☐

## REFERRAL SOURCE

**HOSPITAL:** _____ **CURRENT LOCATION:** ☐ **IP** ☐ **ED** ☐ **OP** ☐ **OP-CHEMO**

**ADDRESS:** _____

**CITY:**_____ **PROVINCE:** _____ **POSTAL CODE:**_____

**REFERRING:** ☐ **MOST RESPONSIBLE PERSON (MRP):** ☐

**PROFESSIONAL DESIGNATION:** _____

**NAME:** _____

**TELEPHONE:** (_____)_____ **EXTENSION:**_____ **FAX:** (_____)_____

**SIGNATURE:** **DATE:**

***CONFIDENTIAL WHEN COMPLETED. IF YOU HAVE THIS FORM IN ERROR PLEASE DO NOT COPY OR DISPOSE OF. CONTACT 416-506-9888 AND WE WILL MAKE ARRANGEMENTS TO COLLECT IT.***

# REFERRAL FORM FOR Ontario Health atHome

*PLEASE PRINT CLEARLY*

**LAST NAME: _____ FIRST NAME: _____**

**HEALTH CARD #: _____ VC:_____**

| MEDICAL INFORMATION | | |
|---|---|---|
| **PRIMARY DIAGNOSIS** | | |
| **SECONDARY DIAGNOSIS** | | |
| **ALLERGIES** | | |
| **RELEVANT MEDICAL HISTORY/ HOSPITAL COURSE** | | |
| **MEDICATION** | **Name: _____Dosage:_____ Frequency: _____ Route: _____Duration: _____**<br>**Name: _____Dosage: ____ Frequency: _____ Route: _____Duration: _____**<br>**Name: _____ Dosage: _____Frequency: _____ Route: _____Duration: _____**<br>**Other:** | |
| **MOBILITY** | **Ambulatory: ☐ Yes ☐ No**<br>**Patient uses: ☐ Wheelchair ☐ Walker ☐ Cane ☐ Scooter**<br>**Other:_____** | |
| **SERVICES REQUESTED** | ***Mandatory Information***<br>1. Identify reason/ need for each service selected<br>2. Provide Treatment Orders and Start Date as applicable<br>3. Include an Estimated Date of Discharge<br>4. For Nursing Service - Patient will receive assessment and treatment at one of the OHaH Nursing Clinics (in-home nursing arranged by exception only)<br>5. Fax referral AND relevant documents together (i.e. script, Palliative Care Referral Form, allied health reports) | |
| ☐ **Nursing** (including Nursing Clinics)<br>☐ **Personal Care** (bathing/dressing)<br>☐ **Dietician/Nutrition**<br>☐ **Occupational Therapy**<br>☐ **Physiotherapy**<br>☐ **Speech Language Pathology**<br>☐ **Social Work**<br>☐ **LTCH Assessment**<br>☐ **Case Management**<br>☐ **Community Linking** (i.e. homemaking) | | |
| ☐ **Palliative Care** | **Prognosis: _____ Palliative Performance Scale (PPS): _____%** | |
| ☐ **Rapid Response Nursing** | ☐ **CHF** ☐ **COPD** | |
| **PHYSICIAN/NP NAME:** | | **OHIP BILLING CODE:_____ CPSO/CNO#:_____** |
| **PHYSICIAN/NP SIGNATURE:** | | **DATE:** |

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