Southlake Community
ONTARIO HEALTH TEAM

Fax Referral form to Central Telehomecare Program: 905-707-2409

COVID@Home Referral Form

Patient Information

Last Name:	**First Name:**	
Date of Birth (DD MM YYYY) .	**Gender:** **Male** ☐ **Female** ☐	**Health Card Number:**
Address:	**City**	
Postal Code:	**Primary Phone Number:**	
First Language: .	**Translator Needed** **Yes** ☐ **No** ☐	**Potential Discharge Date (DD MM YYY)**
Email Address .	**Cell Phone Number**	**Date of Symptom Onset (DD MM YYY)**

Background for Referral (Check all that apply)

☐ COVID-19 Positive
☐ Patient to self-isolate at home
☐ Patient to self-isolate via cohorting space
☐ Patient or caregiver has access to a smartphone or other device that can run apps

How would the patient like to receive notification to participate in the program? (Choose one)

☐ By Email
☐ By Text

☐ Patient does not own smartphone

Risk Factors

☐ Diabetes with complications
☐ Congestive heart failure
☐ Chronic lung disease (i.e. COPD, emphysema) or moderate to sever asthma
☐ Weakened immune syste
☐ Dialysis
☐ Cirrhosis of the liver
☐ Neurological conditions that weaken ability to cough
☐ Pregnancy
☐ Extreme obesity
☐ >= 65 years old
☐ Lives in long-term care facility

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Primary Care Provider's Information

Name: .	**Organization:**
Position: .	**Other Description:**
Address:	
Phone Number: .	**Fax Phone Number:** .
After Hours* Phone Number (if applicable) *after hours is until 8pm:	**CPSO Number:** .

Community Pharmacy

Name:	**Phone Number and Fax Number:**

Emergency Contacts

Name: .	**Name:** .
Relationship – Indicate if primary contact for patient	**Relationship – Indicate if primary contact for patient**
Phone Number:	**Phone Number:**

Other Relevant History (please include baseline Oxygen Saturation Levels)

Medications

☐ Current medication list attached (or can be recorded below)
☐ Contact pharmacy for medication list
List medications and/or additional instructions or notes