Southlake Community
ONTARIO HEALTH TEAM

581 Davis Drive, Suite 202
Newmarket, ON L3Y 2P9

Health Record #: ______________ Complete or place patient label here
Patient Name: *(Print first, last)* ______________
DOB: dd / mm / yy Age: ______ ❑ Female ❑ Male
OHIP #: ______________ Version Code: ______________
Account #: ______________ Date of Admission: dd / mm / yy

COVID@home Referral Form

Fax Referral form to: 905-952-3063

PATIENT INFORMATION

Last Name: *(please print)*	**First Name:** *(please print)*	
Date of Birth: dd / mm / yy	**Gender:** ❑ Male ❑ Female	**Health Card Number:**
Address:	**City:**	
Postal Code:	**Primary Phone Number:**	
First Language:	**Translator Needed:** ❑ Yes ❑ No	**Date of Symptom Onset:** dd / mm / yy
Email Address:	**Cell Phone Number:**	

BACKGROUND FOR REFERRAL *(Check all that apply)*

❑ COVID-19 Positive OR Suspected
❑ 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 a smartphone

Risk Factors:

❑ Diabetes with complications
❑ Congestive heart failure
❑ Chronic lung disease (i.e. COPD, emphysema) or moderate to severe asthma
❑ Weakened immune system
❑ Dialysis
❑ Cirrhosis of the liver
❑ Neurological conditions that weaken ability to cough
❑ Pregnancy
❑ Extreme obesity
❑ Greater than or equal to 65 years old

PRIMARY CARE PROVIDER'S INFORMATION

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

COMMUNITY PHARMACY

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

EMERGENCY CONTACTS

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

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.

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OTHER RELEVANT HISTORY *(Please include baseline Oxygen Saturation Levels)*

MEDICATIONS

❑ **Current medication list attached** *(or can be recorded below)*
List medications and/or additional instructions or notes

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