COVID@Home Referral Form

Fax Referral To: 855-928-5284 **Intake Number: 289-861-5611 ext. 5512**

Program Information

Patient's will be called once a day to assess symptoms and vital signs and provided education on managing their COVID-19 symptoms. Patients will be provided with a pulse oximeter and thermometer. Based on vital sign readings and reported symptoms, the patient may be escalated to their primary care provider or EMS as required. Patient's will be monitored for up to 7 days.
Hours of Operation: 8:00AM-5:00PM, 7 days/week

Patient Information

Name:

D.O.B. (DD/MM/YYYY):

HCN:

Personal Pronoun:

Preferred Language:

Program Criteria

Patient lives at home in Burlington / surrounding areas
Patient is at least 18 years old
Patient tests positive for COVID-19 or has had COVID-19 symptoms within 10 days
Patient presented to ED or hospitalized due to COVID-19 and would benefit from support during transition home
Patient does not require oxygen
Patient consents to being contacted by BFHT to discuss enrollment in the COVID@Home Program

Primary Phone Number (this number will be used to call the patient daily):

Address: City: Postal Code:

Alternate Patient Contact/Substitute Decision Maker Name and Contact Info:

Referral Information

☒ Referral Date (DD/MM/YYYY):

☒ Referral Source Name: Position:

Telephone Number: Fax Number:

☒ Family Physician Name:

Office Telephone Number: Office Fax Number:

Reason for Referral and Clinical Background

☒ Date of confirmed COVID-19 positive case (DD/MM/YYYY):

☒ Date of symptom onset (DD/MM/YYYY): Other Relevant History:

☒ Risk Factors for Deterioration:

☐ N/A ☐ Pregnancy ☐ Cardiovascular Disease ☐ Diabetes Mellitus ☐ Cancer

☐ COPD or other lung diseases ☐ Chronic Kidney Disease ☐ Solid organ or Hematopoietic Stem Cell Transplantation

☐ Smoking ☐ Obesity ☐ Other:

Oxygen Saturation Monitoring

☒ Baseline O_2 Saturation Levels:

☒ Please indicate whether the patient should be monitored using default range or patient specific range: ■ Default ☐ Specific
Vital signs outside the range indicated will trigger a secondary assessment to the care team.

	Default	Patient Specific (indicate range where applicable)
Oxygen Saturation (%)	≥95%	

Please attach Best Medication List and any relevant supporting documentation as applicable.