REFERRAL FORM

London Health Sciences Centre
Urgent COVID-19 Care Clinic

Fax Number: (519) 663-3243

Patient information

Name _____

PIN _____

Phone number _____

Date of birth (dd/mm/yy) _____

Address _____

City _____ Postal Code _____

HCN _____ (version code)

Physicians: Drs. Rasha Abdul-Karim, Lise Bondy, Megan Devlin, Emily Jones, Marko Mrkobrada, Kathryn Myers, Michael Nicholson, Marilyn Phung, and Erin Spicer

INCOMPLETE FORMS CANNOT BE TRIAGED AND WILL LEAD TO DELAYS IN ASSESSMENT

Referring Physician _____ **Date of Referral (dd/mm/yy)** _____

Signature _____ **OHIP Number** _____

Patient being referred from:

☐ Emergency Department at _____ Hospital ☐ Post-Discharge from Hospital

Date of onset of COVID-19 symptoms: _____

Date of positive COVID-19 test: _____ **Circle test: PCR Rapid**

Vaccinated: ☐No ☐1 dose ☐2 doses ☐3 doses+
Date of last dose: _____

Please provide the following <u>mandatory</u> information:

Age _____

Height _____

Weight _____

Interpreter? □ **Yes** □ **No**

Language: _____

Please **check** and **circle** any that apply:

☐ History of heart disease (coronary artery disease, heart failure or arrhythmias)

☐ History of lung diseases (COPD, asthma, interstitial lung disease, bronchiectasis, pulmonary hypertension)

☐ Other: Diabetes, ESRD, pregnant/post-partum

☐ Immunosuppression: _____ (must specify)

☐ Other: _____

☐ NONE OF THE ABOVE

O2 saturation on room air: _____ % **Blood pressure: _____ / _____**

Patient aware of referral: □ **Yes** □ **No**

LHIN's RPM (Remote patient monitoring program) may follow this patient as an alternative to LUC3

Please note: We are not able to accommodate referrals from Long Term Care Facilities at this time. We are happy to discuss patient care with LTC physicians.