HOME AND COMMUNITY CARE SUPPORT SERVICES
South West

Print Reset

COVID-19 Remote Care Monitoring Program (Adults) Referral Form

Please Fax to 519-637-4862, Hours of Operation: Monday to Friday 8:30 a.m. - 4:30 p.m.; outside work hours follow internal escalation pathway. Phone: 1-888-444-8805

Patient Information

LAST NAME	FIRST NAME	DATE OF BIRTH (DD MM YYYY)
HCN		GENDER ◯ MALE ◯ FEMALE
ADDRESS	CITY	
POSTAL CODE	PRIMARY PHONE NUMBER	
FIRST LANGUAGE	TRANSLATOR NEEDED ◯ YES ◯ NO	POTENTIAL DISCHARGE DATE (DD MM YYYY)
EMAIL ADDRESS	CELL PHONE NUMBER	DATE OF SYMPTOM ONSET (DD MM YYYY)
DATE OF CONFIRMED POSITIVE CASE (DD MM YYYY)		
PRIMARY CARE PROVIDER		

Referrer Information

NAME
POSITION
PHONE NUMBER & EXTENSION
EMAIL ADDRESS
PLEASE SELECT YOUR ONTARIO HEALTH TEAM REGION Grey Bruce Huron Perth London - Middlesex Oxford - Elgin
POSTAL CODE

Technology

☐ Patient 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 smart device*

Community Pharmacy

NAME
PHONE NUMBER
FAX NUMBER

Other Relevant History (please include baseline Oxygen Saturation Levels)

*Mandatory fields (please note: incomplete information may result in service delay)

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.