Please email referral to:
OTNtelehomecare19@southlakeregional.org

SOUTHLAKE REGIONAL HEALTH CENTRE

COVID-19 Remote Self-Monitoring Program Referral Form

Patient Information

Add Patient Label

First Language	**Translator Needed** **Yes** **No**
Email Address	**Contact Number**
POTENTIAL DISCHARGE DATE (DD MM YYY)	DATE OF SYMPTOM ONSET (DD MM YYY)

Referral Check List *(check all that apply)*

- ☐ **Provide Patient with an Oximeter Prior to D/C**
- ☐ COVID-19 Positive
- ☐ Medication List Attached

- ☐ 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)

EMAIL **TEXT**

- ☐ Patient does not own a smart device

Referrer Information

Name

Primary Care Provider

Name

Emergency Contacts

Name

Relationship – Indicate if primary contact for patient

Phone

Other Relevant Information *(please include baseline Oxygen Saturation Levels)*

- ☐ *Patient with known COPD–02 Saturation Parameters for this patient are:*_____
- ☐ *Qualifies for home O2?* **Yes** **No**
- ☐ *Home O2 Prescription*_____*LPM*