

COVID-19 Remote Self-Monitoring Program Referral Form

Please fax referral form(s) to: 905-707-2409

PATIENT INFORMATION

(Last Name, First Name)
Home Address: _____

City: _____ **Postal Code:** _____ **Date of Birth:** _____
(dd/mmm/yyyy)
Primary Phone: _____ **Cell Phone:** _____ **Email Address:** _____

First Language: _____ **Translator Needed:** Yes No

Potential Discharge Date: _____ **Date of Symptom Onset:** _____
(dd/mmm/yyyy) *(dd/mmm/yyyy)*
Background for Referral (Check all that apply)

- | | |
|--|--|
| <input type="checkbox"/> Person Under Investigation for COVID-19 | <input type="checkbox"/> Patient has access to smartphone or other device that can run apps |
| <input type="checkbox"/> COVID-19 Positive | How would the patient like to receive notification to participate in the program? (Choose one) <input type="checkbox"/> By Email <input type="checkbox"/> By Secure Text |
| <input type="checkbox"/> Patient to self-isolate at home | |
| <input type="checkbox"/> Patient to self-isolate via cohorting space | <input type="checkbox"/> Patient does not own a smart device |

Risk Factors

- | | | |
|--|---|---|
| <input type="checkbox"/> Diabetes with complications | <input type="checkbox"/> Weakened immune system | <input type="checkbox"/> Pregnancy |
| <input type="checkbox"/> Congestive heart failure | <input type="checkbox"/> Dialysis | <input type="checkbox"/> Extreme obesity |
| <input type="checkbox"/> Chronic lung disease (i.e. COPD, emphysema), or moderate to severe asthma | <input type="checkbox"/> Cirrhosis of the liver | <input type="checkbox"/> 65 years old or older |
| | <input type="checkbox"/> Neurological conditions that weakened ability to cough | <input type="checkbox"/> Lives in long term care facility |

Referrer Information
Name: _____
Position: _____
Phone Number: _____
Email Address: _____

Community Pharmacy
Name: _____
Phone Number: _____
Fax Number: _____

Primary Care Provider's Information

Name: _____	<input type="checkbox"/> Same as above
Position: _____	Name / Address Stamp
Other description: _____	
Organization: _____	
Address: _____	
Phone Number: _____	
Fax Number: _____	

Note: The information contained in this form is confidential. It contains personal health information that is subject to the provincial 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 information in error, please contact the owner or sender immediately.

