



Patient Name _____

Birthdate (dd/mm/yy) _____

Healthcare Number _____ VC _____

Phone Number _____

Transition and Integrated Care

REMOTE CARE MANAGEMENT (RCM) REFERRAL

PHONE: 289-218-6018

FAX: 905-815-5132

Date of Referral: _____

Primary Care Physician: _____ Primary Care Physician Phone Number: _____

Referring Source: _____ Referring Source Phone Number: _____

Preferred Patient Language: _____ Primary Contact Name and Phone Number: _____

CONCERN (Please include details about recent hospital visit/change in medical status if appropriate):

ELIGIBILITY CRITERIA:

<input type="checkbox"/> At least 18 yrs old	<input type="checkbox"/> Lives in Halton Region
<input type="checkbox"/> Does NOT live in Long Term Care	<input type="checkbox"/> Able to use electronic device or has help to use
<input type="checkbox"/> Consents to be contacted by RCM Team	<input type="checkbox"/> Valid Ontario Health Card

PLEASE CHECK THE BOX NEXT TO THE MOST APPROPRIATE PATHWAY BELOW:

<input type="checkbox"/> ACUTE RESPIRATORY	<input type="checkbox"/> COPD	<input type="checkbox"/> CHF	<input type="checkbox"/> PALLIATIVE PROGNOSIS: _____
<ul style="list-style-type: none"> Up to 2 weeks of Remote Care Management 	<ul style="list-style-type: none"> Up to 6 months of Remote Care Management 	<ul style="list-style-type: none"> Up to 6 months of Remote Care Management 	<ul style="list-style-type: none"> Up to 12 months of Remote Care Management
<ul style="list-style-type: none"> No Vital Sign management 	<ul style="list-style-type: none"> Vital Signs management 	<ul style="list-style-type: none"> Vital Signs Management 	<ul style="list-style-type: none"> No Vital Sign Management
<ul style="list-style-type: none"> Diagnosis of viral respiratory illness 	<ul style="list-style-type: none"> Diagnosis of Chronic Obstructive Pulmonary Disease (COPD) 	<ul style="list-style-type: none"> Diagnosis of Congestive Heart Failure (CHF) 	<ul style="list-style-type: none"> Prognosis of 2-12 months. Please note program is NOT appropriate for patients at End of Life.
			<ul style="list-style-type: none"> Includes regular completion of Edmonton Symptom Assessment System (ESAS)

Patient is a current Ontario Health atHome service recipient or recent request to activate Ontario Health atHome services has been submitted

Please fax completed form to [905-815-5132](tel:905-815-5132).. If questions about any of the Remote Care Management pathways please email rcm@haltonhealthcare.com or call 289-218-6018 to speak with a Team Member Monday to Friday 9-5pm (excluding statutory holidays).



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