north simcoe family health team

COVID@Home Referral Form

Fax: 705-526-1205 Phone: 705-526-7804 ext 216

INTEGRATED COMPREHENSIVE CARE PROGRAM

Program Eligibility Criteria
- COVID Positive
- +18 Years of age or older

Referral Source:

Provider _____

Provider Contact Information

Email _____

Fax _____

Phone _____

Goals of Referral

Patient Label Or Patients Name:

_____

Health Card Number: _____

COVID Test Date: _____

Result Date _____

Age: ☐

PatientPhone Number: _____

☐ Private Home/Apt ☐ Retirement Home
☐ Assisted Living ☐ Group Home/Shelter

Private Residence Address

☐ Patient Documents Attached
☐ Medication List Attached

*** Suggested that CPP be attached to Referral**

Any Additional Information:

_____

Current COVID Symptoms (Date):
- ☐ Fever
- ☐ New onset of cough
- ☐ Worsening chronic cough
- ☐ Shortness of breath
- ☐ Difficulty breathing
- ☐ Sore throat
- ☐ Difficulty swallowing
- ☐ Decrease of loss of sense of taste or smell
- ☐ Chills
- ☐ Headaches
- ☐ Unexplained fatigue/malaise/muscle aches

Medical Co-Morbidities
- ☐ Hypertension
- ☐ Ischemic heart Disease
- ☐ Atrial Fibrillation
- ☐ Stroke
- ☐ Diabetes
- ☐ Any Cancer
- ☐ Gastrointestinal Conditions
- ☐ Chronic Liver Disease
- ☐ Chronic Kidney Disease
- ☐ Alcohol or Substance Abuse
- ☐ Psychiatric Disorder
- ☐ Other _____

Referral Source:
- ☐ ED
- ☐ Acute Care Discharge
- ☐ Primary Care
- ☐ Congregate Setting
- ☐ Public Health

Referring Person: _____

Phone Number: _____

Referral Date: _____

Number of Papers Faxed: _____