Community ICC CHF COPD Virtual Pathway Referral

Fax number: 289.408.9915 Phone Number: 905.522.2324

Program Eligibility Criteria

- Diagnosis of CHF or COPD
- +18 Years of age or older
- Able to complete own ADL's

☐ Consent obtained to participate in program

Primary Care Physician: _____

Primary Care Physician Contact Information:

Email _____

Fax _____

Phone _____

Referral Focus

- ☐ Diagnosis Education
- ☐ Medication education and management
- ☐ Action plans
- ☐ Lifestyle
- ☐ Daily living
- ☐ Self management
- ☐ Caregiver support and education
- ☐ Other

Current Diagnosis Status:

- ☐ Newly Diagnosed
- ☐ Advancing disease
- ☐ Dual diagnosis (CHF/COPD)
- ☐ Moderate Disease with educational needs

Does patient have existing services with Home and Community Care Support Services? Yes ☐ No ☐

Other supports in place?:

_____

_____

Medical Co-Morbidities (If Known)

- ☐ 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:

Patients Name:

_____

Health Card Number: _____

AGE :_____ DOB: _____

Patient Phone Number: _____

Emergency contact number_____

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

Private Residence Address:

_____

_____

- ☐ Patient Documents Attached (current and any pertinent past history)
- ☐ Medication List Attached
- ☐ Patient Pharmacy/ Phone number _____

Goals of Referral for Community Connector

- ☐ Information Sharing
- ☐ Caregiver Support
- ☐ Social/Recreation
- ☐ Friendly/Peer Support
- ☐ Meals/Groceries
- ☐ Housing/Assisted Living
- ☐ Transportation
- ☐ Financial/Taxes
- ☐ Identification
- ☐ Home Support
- ☐ Special Supports
- ☐ Reassurance/Security
- ☐ Intervention/Advocacy
- ☐ Health/Mental Health

☐ Email Referral to Community Connector

Referral Source:

- ☐ ED
- ☐ Primary Care
- ☐ Home and Community Care Support Services
- ☐ Caring For My COPD
- ☐ Community Paramedicine
- ☐ Clinic

Referring Person: _____

Phone Number: _____

Date Faxed: _____

Number of Papers Faxed: ____

If you have questions about the program and/or referral process please contact the team at iccvirtualcare@stjhc.ca