Going Home
Retour à la maison

Carefor

Hospital Sticker

Champlain Region

EASTERN COUNTIES
Tel: 613-932-3451
Fax: 613-932-3755
Toll Free: 1-800-267-1741

OTTAWA
Tel: 613-238-8420
Fax: 613-238-9427
Toll Free: 1-877-818-0884

PEMBROKE-RENFREW COUNTY
Tel: 613-732-3949
Fax: 613-732-7114

A GOING HOME PROGRAM REFERRAL FORM

PATIENT INFORMATION

Last Name _____ First Name _____

Date of Birth DD/MM/YYY _____ Phone number _____

Address _____ City _____ Ring # (for apt) _____ Postal Code _____

OHIP _____ Gender: ☐ Male ☐ Female ☐ Other

Language : ☐ English ☐ French Other: _____ Interpreter Required? ☐ Yes ☐ No
Required for Services

Isolation Precautions: ☐ Contact ☐ Droplet ☐ None

Discharge facility on outbreak : ☐ Yes ☐ No

If admitted to hospital :

Hospital Admission Date DD/MM/YYY _____

Discharge Date DD/MM/YYY _____

If patient wasn't admitted :

Emergency Department Visit Date DD/MM/YYY _____

Reason for Hospital Visit _____

Emergency Contact :

First Name _____ Last Name _____

Home Phone _____ Cellphone _____ Work _____ Ext. _____

Relationship to Patient _____ Lives with Patient? ☐ Yes ☐ No

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REFERRAL SOURCE

- ☐ Almonte General Hospital
- ☐ Arnprior & District Hospital
- ☐ Carleton Place & District Memorial Hospital
- ☐ Cornwall Community Hospital
- ☐ Deep River & District Hospital
- ☐ Elisabeth Bruyère Hospital (Bruyère Continuing Care)
- ☐ Glengarry Memorial Hospital
- ☐ Hawkesbury & District General Hospital
- ☐ Kemptville District Hospital
- ☐ Montfort Hospital
- ☐ Pembroke Regional Hospital
- ☐ Perley Rideau Veteran's Health Centre - Safe Unit
- ☐ Queensway Carleton Hospital
- ☐ Renfrew Victoria Hospital
- ☐ Royal Ottawa Health Care Group
- ☐ St. Francis Memorial Hospital
- ☐ St. Joseph's Continuing Care Centre
- ☐ St. Vincent Hospital
- ☐ The Ottawa Hospital - Civic Campus
- ☐ The Ottawa Hospital - General Campus
- ☐ The Ottawa Hospital - Rehab Centre
- ☐ University of Ottawa Heart Institute
- ☐ Winchester District Memorial Hospital
- ☐ Other

Person Completing Referral :

☐GEM Nurse ☐Discharge Planner ☐ LHIN Care Coordinator ☐ Social Worker ☐Other: _____

Last Name First Name

Work Phone Ext. Pager

Signature Date DD/MM/YYY

By signing this form, I confirm that the client has consented to this referral.

SERVICE REFERRAL

Select which services referring to :

☐Meals on Wheels :
- ☐Home Delivery
- ☐Client Pick-Up

☐In-home Services :
- ☐Personal Support
- ☐Homemaking

☐ Transportation Services:
- ☐ Hospital to Home
- ☐ Follow up appointments

☐ **If Transportation Services are requested, complete both sections A AND B.**

ADDITIONAL INFORMATION

Allergies

Home Precautions :
- ☐ Pets
- ☐ Hoarding
- ☐ Smoking/Vaping
- ☐ Pests
- ☐ Exposure to contagious vermin (bedbugs,scabies)

Has referral to HCC been made for or is the patient already receiving PSS? ☐ Yes ☐ No

Date of Referral DD/MM/YYY ☐ Waitlisted

Comments on other concerns (e.g. mental health, physical health, cognitive issues applicable to provision of services) :

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B GOING HOME HOSPITAL TO HOME TRANSPORTATION REFERRAL

To accompany Going Home Referral Form for those who require transportation home from hospital.

PATIENT INFORMATION - TRANSPORTATION HOME

Last Name _____ First Name _____

Pick-up Date _____ Time Patient Ready _____ Hospital _____ Patient Floor and Room # _____

Destination Address (if not home address) _____

Client has house key? ☐ Yes ☐ No _____ Provide name and phone number of person who will be present to unlock door

Is client traveling alone? ☐ Yes ☐ No _____ Provide name of person accompanying client home

Prescription Pick-up? ☐ Yes ☐ No

Please note:
Prescription must be faxed in advance and ready upon arrival and client must have money to pay for prescription.

Has the prescription(s) been faxed? ☐ Yes ☐ No Will client be provided with prescription money? ☐ Yes ☐ No

Pharmacy Name _____ Pharmacy Address _____

CLIENT DETAILS:

Client has own portable oxygen? ☐ Yes ☐ No

Client has appropriate clothing for travel (i.e. shoes, coat, blanket)? ☐ Yes ☐ No

There is a 1 bag maximum for transportation. Please confirm, client has 1 bag: ☐ Yes ☐ No Bag

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Client requires manual wheelchair for travel to be provided? ☐ Yes ☐ No

Hospital providing loaner chair ? ☐ Yes ☐ No

House has ramp for a wheelchair? ☐ Yes ☐ No

Mobility Aid is:
☐ Required ☐ Not Required

Location of aid if required:

☐ At home

With patient in hospital

☐ Wheelchair (electric)
Client Weight (lbs) _____

☐ Wheelchair (manual)
Client Weight (lbs) _____

☐ Walker

☐ Cane

Client able to transfer to/from vehicle? ☐ Yes ☐ No

Number of Steps: To access house _____ Inside house _____

Is laneway and door access cleared for entry? ☐ Yes ☐ No

Can client walk up steps to access house & inside house?

Yes - independently ☐ Yes - With supervision ☐

Yes - With arm assist ☐ No ☐

Comments on other transportation concerns: