



Going Home
Retour à la maison



Champlain Region

EASTERN COUNTIES Tel:
613-932-3451 ext 7
Fax: 613-932-3755

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

PEMBROKE-RENFREW COUNTY
Tel: 613-732-3949 ext 7
Fax: 613-732-7114



GOING HOME PROGRAM REFERRAL FORM

PATIENT INFORMATION

Last Name First Name

Date of Birth DD/MMM/YYYY 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/MMM/YYYY

Discharge Date DD/MMM/YYYY

If patient wasn't admitted :

Emergency Department Visit Date DD/MMM/YYYY

GEM assessment completed DD/MMM/YYYY

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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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

Hospital Sticker

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: