HealthLink
Muskoka HealthLink
Let's Make Healthy Change Happen

Muskoka Health Link facilitates bringing care providers together to coordinate and improve care delivery for individuals living with complex and chronic health needs.

Patient/Client Eligibility

Step 1: Checklist and Referral Information

***INSTRUCTIONS:* Please securely fax completed form and consent to 705-645-9358.**

A. PATIENT/CLIENT INFORMATION

Eligibility Assessment Date: _____

Patient / Client Name: _____

Date of Birth: _____
(Health Link is NOT age specific)

Client Phone: (_____) _____

Gender: ☐Female ☐Male

Heath Card Number: _____

Town/Community: _____

(Please include HC version code, e.g. xxxx xxx xxx AA, where AA = version code)

B. HEALTH LINK (HL) PATIENT/CLIENT IDENTIFICATION

*Using the criteria below, is the individual living with complex conditions a **high user** of the health system and/or **at risk of becoming a high user**? (Please check all that apply.)*

☐ Individual Hospitalized in the last 3 months	☐ 1 or more visits to the emergency department in the last month	☐ Greater than 3 contacts with Primary Care Provider in the last month

☐ Greater than 3 organizations providing care to this individual

Please list, if known. Note: if more than 5, please document in the Client's Coordinated Care Plan.

Organization	Contact Name	Contact Email	Contact Phone

C. HEALTH LINK (HL) CRITERIA

*Does the patient also meet **4 or more** of the identified criteria below? (Please check all that apply.)*

☐ Lives Alone	☐ Caregiver Burnt Out	☐ Cognitive Impairment / Dementia
☐ Poor Nutrition	☐ Chronic Disease(s) (e.g. diabetes, CHF, COPD, cancer, other): ***Please list.***	☐ Mental Health Issues (e.g. depression, bipolar, PTSD, schizophrenia, other): ***Please list.***
☐ Failure to Cope at Home		
☐ Low Income/ Ontario Works / ODSP		
☐ Frail	☐ Addiction Issue(s) (e.g. alcohol, smoking, drugs, gambling, other): ***Please list.***	☐ Identified Disability (e.g. physical, visual, hearing, other): ***Please list.***
☐ Multiple Medications (5+)		
☐ Risk of Falling		
☐ End of Life / Palliative		☐ Other: ***Please list***.

When your health becomes more complicated, you often have more appointments, confusion with knowing the providers and what they do and maybe duplication or missed appointments. Health Link puts you in the centre with all of your providers working together to better coordinate care for you by developing a care plan to meet your needs.

D. ACCESS TO PRIMARY CARE

Does Patient/Client have a Primary Care Provider (PCP)? ☐Yes ☐No

If Yes, provide name of PCP: _____ PCP Phone: (_____) _____

E. HEALTH LINK (HL) CARE TEAM

Name of person who completed this form: _____

Title: _____ Organization: _____

Email: _____ Phone: (____) _____

Has a Coordinated Care Plan (CCP) been developed? ☐**Yes** ☐**No** *(CCP includes Name of System/Care Navigator, Names of Care Team Members, Summary of Patient/Client Needs and Goals, Linkage to Advanced Care Planning if appropriate, and has been developed with Patient/Client and/or Caregiver, System/Care Navigator, and Care Team.)*	
If Yes, provide the date when the CCP was developed *(mm/dd/yy):*	**If Yes,** please provide the name of the organization/agency where the CCP is stored:
If No, the CCP has not yet been started, please identify reason:	
Provide Name of Primary Health Contact / System Navigator *(e.g. Care Coordinators, Social Workers, Nurse Practitioners, Case Managers, others)*:	Provide Email and Phone of Primary Health Contact / System Navigator: Email: _____ Phone: (____) _____

F. HEALTH LINK (HL) PATIENT/CLIENT CONSENT

Patient and/or Health SDM/POA Accepts HL Service and has Completed HL Consent Form:

☐**Yes** ☐**No** **If No**, please identify reason: _____

Please ***fax*** completed
Health Link ***CLIENT ELIGIBILITY FORM*** and
signed Health Link ***CONSENT FORM*** to:

705-645-9358

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