COMMUNITY PARAMEDICINE (CP)
HOME VISIT / HEALTH LINK (HL) REFERRAL

Please fax to: 705-646-9011

HealthLink
Muskoka HealthLink
Let's Make Healthy Change Happen

☐ CP Referral ☐ HL Referral ☐ CP & HL Referral

PATIENT/CLIENT INFORMATION

Eligibility Assessment Date: _____

Patient / Client Name: _____

Date of Birth: _____
(yyyy/mm/dd)

Address: _____

Client Phone: _____

Town/Community: _____

Gender: ☐ Female ☐ Male ☐ Other

Heath Card Number (with version code): _____

Check any that apply: ☐Indigenous (First Nations, Metis, Inuit) ☐Veteran ☐French-speaking
(There may be additional services and resources available if any of these are relevant.)

Referred by: _____

Phone number: _____

Fax: _____

Email: _____

Reason for referral:

CURRENT SUPPORTS

☐ Home and Community Care	☐ Rapid Response nurse (within 1 week of this referral)	☐ SASOT
☐ Palliative Care Team	☐ Private care (i.e. PSW support)	☐ Meals on Wheels
☐ The Friends	☐ CMHA	☐ Unknown or No Supports
☐ Community Living	☐ Algonquin FHT Geriatric Care Team	☐ Community and/or social services (i.e. Ontario Works, ODSP, Housing, Homelessness, etc). **Please list:**
☐ Veterans Affairs	☐ Other. **Please list:**	
☐ Wound care		

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ELIGIBILITY CRITERIA

Please select all that apply. Patient/Client must meet **at least three (3)** of the following criteria;

☐ Individual admitted to hospital or visited the ED at least twice in the last 30 days	☐ Greater than 3 contacts with Primary Care Provider in the last 30 days	☐ Rapid deterioration of normal state and no in-home services available
☐ Lack of or absence of community supports OR community supports cannot visit within 10 days post-discharge	☐ 1 Addiction Issue(s) (e.g. alcohol, smoking, drugs, gambling, other): ***Please list*:**	☐ Chronic Disease(s) (e.g. diabetes, CHF, COPD, cancer, other) and inability to attend Pulmonary Rehab or Healthy Heart programs: ***Please list*.**
☐ End of life / palliative		
☐ Isolation or lack of support system	☐ Mental Health Issues (e.g. depression, bipolar, PTSD, schizophrenia, other): ***Please list*:**	☐ Other: ***Please list*:**
☐ Frail/fall risk		
☐ Failure to cope at home or caregiver burnout		

REQUESTED SERVICES

☐ Wellness check	☐ Blood draw (please include requisition) MUST BE HOMEBOUND TO RECEIVE THIS SERVICE	☐ Edmonton Symptom Assessment
☐ IV placement	☐ Vision clarity scan	☐ Vital signs
☐ Postural hypotension assessment	☐ Diabetic foot assessment	☐ Nutrition assessment
☐ Mental health assessment (cognitive exam & depression scale)	☐ Chronic Disease assessment. ***Please list.***	☐ OTN appointment: ***Please list.***
☐ Environmental/Home Safety assessment		
☐ Remote Care Monitoring Referrals for CHF, COPD, and/or Diabetes may be forwarded to a MAHOT RCM clinical nurse navigator		
☐ Medication review/compliance	☐ Physical assessment: ***Please list specific assessments.***	☐ Images (i.e. wound, environment etc.): ***Please list.***
☐ Palliative Performance Scale		
☐ Fall Risk Assessment		
☐ Caregiver assessment		☐ Other: ***Please list*.**
☐ Montreal Cognitive Assessment		

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INTAKE ASSESSMENT

Are there problems in the home that would contribute to adverse outcomes?	Has the client called 911 or visited the ED in the last 30 days?	Are the client's medications disorganized?
☐ Yes	☐ Yes	☐ Yes

PRIMARY CARE

Does Patient/Client have a Primary Care Provider (i.e. Family physician, nurse practitioner)? ☐Yes ☐No

If yes, provide name: _____ Phone:_____

Secure fax number: _____

PATIENT CONSENT

Has the patient verbally consented to being referred to and contacted by both the Community Paramedicine and Health Link Programs: ☐**Yes**

(**Please note:** consent must be obtained by the *referring agency* prior to an initial visit)

ADDITIONAL INFORMATION (please include any safety risks such as dogs, access issues, hoarding etc.)

THE DISTRICT MUNICIPALITY OF MUSKOKA

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FOR HEALTH LINK REFERRALS ONLY

The District Municipality of Muskoka
Consent for the Collection, Use and Release of Information

Department: _____

Client Name:_____ Date of Birth:_____

Address: _____

City:_____ Province: _____ Postal Code:_____

E-mail Address:_____Phone Number: _____

Consent to leave a voicemail at (circle your response): Phone Number: Yes / No

The District Municipality of Muskoka is committed to protecting the privacy and security of your personal information and personal health information. You have the right to choose how your information will be collected, used, and shared by The District Municipality of Muskoka subject to some exceptions which we can explain to you.

By signing this consent form, you agree to permit The District Municipality of Muskoka to provide your personal information and/or personal health information to other program areas within the District, and to external service agencies and professionals to coordinate, plan, identify and deliver programs and services to you.

I,_____consent to The District Municipality of Muskoka sharing my information with other District Programs and with external service agencies and professionals.

I have also been provided an opportunity to ask questions of a representative of The District Municipality of Muskoka related to this consent and my questions were answered.

I understand that if I do not wish to have my information shared, I am still eligible for the service(s) I receive.

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I also understand there are some situations where The District Municipality of Muskoka does not need my permission to share my information with other District programs or others. For example, this would include situations where the District is permitted or required by law to act such as if a child needs protection or in the case of the potential for serious harm to me or someone else.

Client Signature	Date
Substitute Decision Maker (if applicable)	Date
Department / Staff Member & Title	Date

Notice with Respect to the Collection of Personal Information

Personal information that is the subject of this consent is collected by The District Municipality of Muskoka in accordance with the *Municipal Freedom of Information* and *Protection of Privacy Act and the Personal Health Information Protection Act, 2004* for the purpose of providing you with social and health services.

For more information, contact the Health Services Commissioner at:

The District Municipality of Muskoka
Health Services Department
70 Pine Street, Bracebridge, ON P1L 1N3
Phone: (705) 645-2100 extension: 4670