

# Community Remote Patient Monitoring Program Referral

**Fax Referral To: 855-928-5284**

**Intake Number: 289-208-9619**

## Program Information

Technology will be set up in the patient's residence at no cost to monitor and provide education on managing the following chronic disease: (COPD/CHF) or being a vulnerable senior. This program is an additional resource to assist the patient in improved self-management and navigating health and social services. The family physician will be consulted if medical needs arise that fall outside the scope of this program via fax or telephone.

## Patient Information

Name: \_\_\_\_\_

Preferred Pronoun: \_\_\_\_\_

Preferred Language: \_\_\_\_\_

D.O.B.: \_\_\_\_\_

Contact Number: \_\_\_\_\_

Alternate Patient Contact/Substitute Decision Maker: \_\_\_\_\_

**Office Use Only:** Can a detailed phone message be left?  No  Yes

## Program Criteria

Patient lives at home in Burlington / surrounding areas
Patient is living with chronic condition (COPD, CHF)
<b>OR</b>
Patient is a vulnerable senior
Patient is at least 18 years old for COPD/CHF monitoring
Patient is at least 60 years old for vulnerable senior monitoring
Patient consents to contact from BFHT to discuss program enrollment

## Physician Information

Referring Physician Name: \_\_\_\_\_

Office Telephone Number: \_\_\_\_\_ Office Fax Number: \_\_\_\_\_

Family Physician Name: \_\_\_\_\_

Office Telephone Number: \_\_\_\_\_ Office Fax Number: \_\_\_\_\_

Respiriologist Name and Contact Information (if applicable): \_\_\_\_\_

## Reason for Referral

Diagnosis:  COPD  CHF  Vulnerable Senior

Clinical/Social Background: \_\_\_\_\_

Comorbidities: \_\_\_\_\_

Does the patient have allergies/hypersensitivities?  No  Yes: \_\_\_\_\_

Would the patient benefit from Smoking Cessation?  No  Yes

**\*\*Fill out the following Section for Chronic Disease Monitoring ONLY\*\***

## Vital Sign Monitoring

Would the patient benefit from daily weight monitoring?  No  Yes - Weigh daily; set alert for weight

Baseline Weight <input type="checkbox"/> kg. <input type="checkbox"/> lbs.		Baseline Height (cm)	
Min Daily Weight		Max Daily Weight	
Max weight lost delta	_____ per _____ day	Max weight gained delta	_____ per _____ day

**Please indicate whether patient should be monitored using default range or patient specific range:**

Use Default Set:  Blood Pressure  Heart Rate Use Specific Set:  Blood Pressure  Heart Rate

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Oxygen Saturation

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Vital Sign	Default		Patient Specific (indicate range where applicable)	
	Min	Max	Min	Max
Blood Pressure				
SBP mmHg	90	160		
DBP mmHg	45	110		
Heart Rate (bpm)	60	110		
Oxygen Saturation (%)	≥95%	N/A		

Does the patient have a pacemaker:  No  Yes (enter lower limit for bpm): \_\_\_\_\_bpm

## Diabetes Monitoring

Would the patient benefit from Diabetes Monitoring (in addition to CHF/COPD Monitoring)?  No  Yes

Does the patient use insulin?  No  Yes:

Insulin Type:

(Apidra® (Insulin Glulisine))  Humalog® (Insulin lispro)  NovoRapid® (Insulin Aspart, Humulin R, Novolin GE)

**Please indicate whether patient should be monitored using default range or patient specific range:**

Use Default to Adjust Blood Glucose Threshold values

Use Specific to Adjust Blood Glucose Threshold values

	Default		Patient Specific (indicate range where applicable)	
	Min	Max	Min	Max
<b>Sliding Scale (mmol/L)</b>	10.1-12 → 2 units	12.1-14 → 4 units		
<b>Fasting (mmol/L)</b>				
Severe hypoglycemia	0	3.0		
Mild hypoglycemia	3.1	3.9		
Normal	4	7		
Mild hyperglycemia	7.1	20		
Severe hyperglycemia	20.1	X		
<b>Prandial (mmol/L)</b>				
Severe hypoglycemia	0	2.7		
Mild hypoglycemia	2.8	3.9		
Normal	4	10		
Mild hyperglycemia	10.1	20		
Severe hyperglycemia	20.1	X		

How often should blood glucose be checked?

Once in morning

Three times a day

Four times a day

Once a day at bed time

Access to fast-acting carbohydrate for hypoglycemia?  No

Yes

**Please attach Best Medication List and any relevant supporting documentation as applicable.**