Georgian Bay
FAMILY HEALTH TEAM

COVID-19 Home Monitoring Program

Referral to GBFHT/COVID Assessment Centre

Telephone: 705-444-5885 Fax Number: 705-444-1393

Patient information

Last Name: _____ First Name:_____ Date of Birth: _____

HCN: _____VC _____ Gender/pronoun: _____

Address: _____City/Town: _____

Postal Code: _____Telephone: Home _____Cell _____

COVID-19 History

☐Presumed Case ☐Confirmed Case Date of Positive Result _____
Referred by: _____ Contact #: _____ Date:_____

Relevant only for hospital or ER discharge if packages available on units:

☐Provided 02 Sat monitor and instructions in its use. Patient demonstrated understanding.

☐ Provided and discussed checklist of red flags (Appendix A in package). Patient demonstrated understanding, what to do in the event of deteriorating symptoms, and when to seek emergency care.

☐Patient aware of contact numbers in event of concerns (Appendix A in package).

Health Status, medications prescribed for treatment of COVID-19

_____

_____

Clinical Exam

Temperature: _____ 02 Sat: _____ BP/P: _____

Chest exam: _____

☐Patient advised that they will be contacted by Georgian Bay Family Health Team/COVID Assessment Centre on daily basis until discharge.

Preferred contact number: _____

☐Patient gives consent to participate and for information to be provided to primary care provider.

Primary Care Provider_____ Contact # _____

☐Patient's alternate contact (if required) – has been made aware of the pathway process.
Name_____ Contact #_____ Relationship _____

Please complete this form and fax to GBFHT/COVID-19 Assessment Centre 705-444-1393