Hospital at Home Referral Form

Referring Unit/Area or Provider: PLEASE COMPLETE THE FOLLOWING

PATIENT INFORMATION	REFERRING INFORMATION	
Last name:	Referring MRP:	
First name:	Referring Unit:	
Date of birth Year Month Day:	Admission date:	
MRN:	Diagnosis:	
Postal code:	MRP aware of referral? □ yes □ no	
□ Violence alert □ Disease alert specify_____	Referring Site:	□ Royal Jubilee Hospital □ Victoria General Hospital □ Cowichan District Hospital □ Other
Additional information:		

DEMOGRAPHICS	Yes	No	Unknown
19 Years old or over	□	□	□
Safe home environment	□	□	□
Phone in the home	□	□	□
Fridge in the home	□	□	□
Lives less than 25 minute drive from RJH or VGH or CDH	□	□	□
Caregiver in the home	□	□	□
OTHER CONSIDERATIONS	Yes	No	Unknown
Active home supports	□	□	□
Long term care/assisted living	□	□	□
Mobility concerns	□	□	□
Cognition/sensory concerns	□	□	□
PT/OT involvement	□	□	□
Fall risk	□	□	□
Language barrier	□	□	□

CLINICAL CHARACTERISTICS	Yes	No	Unknown
Requires hospital-level care	□	□	□
Known diagnosis	□	□	□
Clinically stable	□	□	□
Expected length of stay less than 10 days	□	□	□
Will require multiple in-hospital tests, treatments or consultations	□	□	□
Ambulatory to bathroom	□	□	□
Able to provide self-care	□	□	□
Pain crisis	□	□	□
Acute stroke	□	□	□
Active psychiatric disorder	□	□	□
Active substance use disorder	□	□	□

Note: Please complete **all** fields. Incomplete forms may lead to delays in referrals being reviewed.

Please fax completed forms to Hospital at Home			
	Royal Jubilee Hospital	**Office**: 250-370-8156	**Fax:** 250-370-8188
	Victoria General Hospital	**Office**: 250-727-4397	**Fax:** 250-727-4013
	Cowichan District Hospital	**Office**: 250-737-2030 ext 44331	**Fax:** 250-709-3018

Date referral sent:	Date referral reviewed:	Total # of pages:

If you have questions or would like to suggest changes to this form, please contact RegionalClinicalForms@islandhealth.ca