island health

# Hospital at Home Referral Form

## Referring MRP or Unit/Area: 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<br>□ Disease alert *specify*_____ | Referring Site: □ Royal Jubilee Hospital<br>□ Victoria General Hospital<br>□ 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 | □ | □ | □ |
| 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 |

| 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@viha.ca