RESOURCE TOOLKIT:

COVID @ Home Halton Program

PRIMARY CARE INFORMATION

June 1, 2021
Welcome to the COVID@Home Halton Program

Welcome to the COVID@Home Halton program. This program will provide resources to family physicians in the community so that they can care for complex patients who test positive for COVID and require closer monitoring of symptoms. The program is offered by Connected Care Halton Ontario Health Team and will bring together support from Home and Community Care Support Services (our local government-funded home care coordination service), Halton Healthcare Services (our local hospital system), Emergency Medical Services (particularly the Halton paramedicine service), Ontario Health (Central) as well as clinical expertise from family physicians like yourself.

Not all patients who test positive for COVID will require monitoring as it is a self-resolving illness. However, some will require closer check-ins to make sure they don't deteriorate without seeking medical attention. In addition, patients whose goals of care include palliation will require support to monitor and care for them. The goal of the program is to provide additional resources in the community to offload the stress facing our local hospital system. The program will include access to nurse navigators, General Internal Medicine support through the nurse navigator, ordering oxygen for palliative patients, and information on after-hours support. Similar programs are running in Toronto, Peel, and York Region and other areas in southern Ontario.

On the following pages, you will find:
1. Clinical pathways to show how family physicians can monitor patients during daytime office hours and how they can arrange monitoring of high risk patients after-hours and on weekends.
2. Clinical pathways for family physicians who do not have the in-office resources to monitor patients during daytime hours.
3. Information on how to access the COVID@Home Halton program.
4. Information on when to send patients to the ER.
5. Information on suggested monitoring frequency based on risk-stratification of patients, provided by the Hamilton Family Medicine group.
7. Information on how to order funded pulse oximeters from the Ministry of Health.
8. A patient toolkit.

Please note that this is a primary care led program and so family doctors are the Most Responsible Providers for these patients and the resources to support them.
COVID @ Home Halton: Primary Care Monitoring

June 1, 2021

1. Patient self-identifies to Primary Care
2. Primary Care determines whether to refer patient to the COVID @ Home Halton Program
3. Primary Care discusses goals of care with patient. *For Palliative Patients this includes planned death at home*
4. Primary Care assesses equipment needs of patient (e.g. oximeter) and arranges delivery/pick up if needed
5. Primary Care sends referral to Home & Community Care enrolling patient in COVID @Home Halton Program

Primary Care monitors patients during regular business hours Mon-Fri according to risk stratification

Primary Care provides patient education/information on how to self-monitor

Concerns or issues arise (e.g. symptom escalation)

During Regular Business Hours:

- Primary Care to call SCOPE Navigator at 289-952-2457. SCOPE Navigator to determine if General Internal Medicine or Respirologist On-Call consult is required and if so, assist with warm hand-off.
- Send to Emergency Department (for criteria see Physician Toolkit #7)

After Regular Business Hours:

- Patient calls Home & Community Care 24/7 Help Line 905-855-9090
- Home & Community Care assesses patient over the phone and determines needs
- If required, Halton Community Paramedics called to assess (after 5pm Mon – Fri and weekends)
- If required, call to 911 and patient to Emergency Department
- Home & Community Care to provide communication back to Primary Care
### Mississauga Halton LHIN Referral Form

**Enrollment in COVID @ Home Halton Program - Primary Care to Monitor**

**Referral information:**
- Community Referral
- Hospital Referral

**Planned Date of hospital discharge:**

**Name of person referring:**

**Contact Information:**

**Reasons for Referral:**

**Diagnosis/Significant Medical Information:**

**Patient Demographics:** affix label if appropriate
- **Patient Name:**
- **DOB:**
- **HCN:**
- **Phone:**
- **Gender:** ☑ Male ☐ Female
- **Allergies:**
- **Diabetic:** ☑ Yes ☐ No

**Service Requested**

- **Nursing - Wound Care**
  - Ambulatory Patients will receive their nursing care in a LHIN Nursing Clinic.
  - For all wound care orders include wound etiology and wound dimensions
  - Specific Wound Care Orders:

- **Nursing - IV**
  - **IV Medication:**
    - **Name of Medication:**
    - **Dose:**
    - **Frequency:**
    - **Duration:**
    - **Date & Time Last Dose Given:**
  - **Route:** ☑ PICC ☐ Port-A-Cath ☑ Peripheral IV
  - **Screening for 1st dose administration at home:**
    - History of serious adverse or allergic reaction to the prescribed medication or related compound?
      - Yes ☑ No ☐
    - Patient currently on beta-blockers, A.C.E inhibitors and anti-adrenergic drugs?
      - Yes ☑ No ☐
  - **IF NO to above - Ok to administer 1st dose in home?**
    - Yes ☑ No ☐

- **IV Access Route Care:**
  - (All Heparin orders please indicate in IV Additional Specific orders)
  - **Peripheral:** Flush 2-3cc 0.9% NS OD
  - **Tubing Change:** Q3 Days
  - **Dressing:** Q weekly PRN
  - **Valved PICC:** Flush 0.9 % NS 10 ml
    - Frequency: after each access or weekly if not it use
    - **Dressing & Cap Change:** Q weekly PRN
  - **Non-Valved PICC:** Flush 0.9 % NS 10ml followed by 300 units of Heparin.
    - Frequency: after each use or weekly if not in use.
    - **Dressing & Gripper Change:** Q7 weekly & PRN
  - **Port-a-cath:** Flush 0.9% NS10-20/ml followed by 500 units of Heparin
    - Frequency: After each use or every 4 weeks if not in use.
    - **Dressing & Gripper Change:** Q7 weekly & PRN
  - **Gripper Size:**

- **IV Additional Specific Orders:**
  - (eg. Hickman, Midline, any additional Heparin orders)

- **Nursing - Other**
  - e.g. Catheter, Ostomy, drains, etc.

- **Physiotherapy**

- **Speech Language Pathology**

- **Occupational Therapy**

- **Personal Support**
  - (eg. bathing, dressing)

- **Social Work**

- **Dietetic Service**

- **Rapid Response Nurse**

- **Navigation to Community Supports**

- **Caregiver Respite**

- **Health Links**
  - Lives Alone ☑ Limited social network ☐ Community Service Use ☑ Finances ☑ Transportation ☐ Housing
  - Mobility ☑ Home Bound

- **Physician/NP Signature required for Nursing and PT weight bearing:**

**Print Name and Phone number:**

**Billing Code:**

**Date:**

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**M-H LHIN Main Office – 2655 North Sheridan Way, Mississauga, ON**

**Main Office Fax:** (905) 855-8989  **Toll Free 1-877-298-8989**

**Main Office Phone:** (905) 855-9090  **Toll Free 1-877-336-9090**

*Hospital in-Patient please use Hospital LHIN office Fax*

Form 8 CS ACCESS 001 revised March 19, 2018
COVID @ Home Halton: Home & Community Care Monitoring

June 1, 2021

Primary Care determines whether to refer patient to COVID @ Home Halton Program.

Primary Care discusses goals of care with patient. For Palliative Patients this includes planned death at home.

Primary Care assesses equipment needs of patient (e.g. oximeter) and arranges delivery/pick up if needed.

Primary Care does not have capacity to monitor patient Mon-Fri daytime hours (See Physician Toolkit # 5 for Criteria).

Concerns or issues arise (e.g. symptom escalation).

Home & Community Care monitors patients during regular business hours Mon-Fri according to risk stratification.

Home & Community Care provides patient education/information on how to self-monitor.

Patient self-identifies to Primary Care

Primary Care sends referral to Home & Community Care enrolling patient in "COVID @Home Halton Program: Home & Community Care to Monitor. Primary Care remains MRP

During Regular Business Hours:

Home & Community Care to call SCOPE Navigator at 289-952-2457. SCOPE Navigator to determine if General Internal Medicine or Respirologist On-Call consult required.

OR

Send to Emergency Department

After Regular Business Hours:

Patient calls Home & Community Care 24/7 Help Line 905-855-9090.

Home & Community Care assesses patient over the phone and determines needs.

If required, call to 911 and patient to Emergency Department (for criteria see Physician Toolkit # X).

Home & Community Care to provide communication back to Primary Care.
Eligibility Criteria for Home and Community Care Monitoring

The eligibility Criteria for Home and Community Care Monitoring is as follows:

1) Solo practitioner unable to support the number of patients on his/her roster requiring monitoring/extent of monitoring required
2) Primary Care Provider who requires support with monitoring patients on weekends
3) Patient being referred with no Primary Care Provider
## Mississauga Halton LHIN Referral Form

Anyone can make a referral to the LHIN. Physician signature only required for Nursing and Physiotherapy Weight Bearing. Please Note: To ensure patient safety and continuity of care, please ensure the LHIN referral is completed in full. Palliative referrals: Please send separate Palliative referral form CS PAL.

### Referral Information:
- **Community Referral**
- **Hospital Referral**
- Planned Date of hospital discharge:

### Contact Information:
- Name of person referring:
- Reasons for Referral:
- Diagnosis/Significant Medical Information:

### Patient Demographics:
- Affix label if appropriate
- **Patient Name:**
- **Home Address:**
- **DOB:**
- **HCN:**
- **Phone:**
- **Gender:**
- **Allergies:**
- **Diabetic:** Yes / No

### Service Requested:
- **Nursing - Wound Care**
- Ambulatory Patients will receive their nursing care in a LHIN Nursing Clinic.
- **Nursing to Assess and Treat**
- **Specific Wound Care Orders**

### IV Medication:
- **Name of Medication:**
- **Dose:**
- **Frequency:**
- **Duration:**
- **Date & Time Last Dose Given:**
- **Route:** PICC / Port-A-Cath / Peripheral IV

### IV Access Route Care:
- **Peripheral:** Flush 2-3cc 0.9% NS OD
- **Tubing Change:** Q3 Days
- **Dressing:** Q weekly PRN

- **Valved PICC:** Flush 0.9% NS 10 ml
- **Frequency:** after each access or weekly if not use
- **Dressing & Cap Change:** Q weekly PRN

- **Non-Valved PICC:** Flush 0.9% NS 10ml followed by 300 units of Heparin
- **Frequency:** after each use or weekly if not in use.
- **Dressing & Gripper Change:** Q7 weekly & PRN

- **Port-a-cath:** Flush 0.9% NS10-20/ml followed by 500 units of Heparin
- **Frequency:** After each use or every 4 weeks if not in use.
- **Dressing & Gripper Change:** Q7 weekly & PRN

### IV Additional Specific Orders:
- **Nursing – Other**
  - e.g. Catheter, Ostomy, drains, etc.
- **Physiotherapy**
- **Speech Language Pathology**
- **Occupational Therapy**
- **Personal Support**
  - e.g., bathing, dressing
- **Dietetic Service**
- **Rapid Response Nurse**
- **Navigation to Community Supports**
- **Caregiver Respite**
- **Health Links**

### Physician/NP Signature required for Nursing and PT weight bearing:
- **Print Name and Phone number:**
- **Billing Code:**
- **Date:**

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M-H LHIN Main Office – 2655 North Sheridan Way, Mississauga, ON
Main Office Fax: (905) 855-8989 Toll Free 1-877-298-8989
*for Community and Hospital Emergency Departments
*Hospital In-Patient please use Hospital LHIN office Fax
Main Office Phone: (905) 855-9090 Toll Free 1-877-338-9090
Form # CS ACCESS 001 revised March 19, 2018
Consider emergent transfer to ED (unless not congruent with goals of care*) if:

- HR >110, SPO2 consistently ≤ 92%, RR >24
- Severe shortness of breath at rest (e.g. Breathlessness RR >30 despite normal O2 sats)
- Difficulty in breathing (work of breathing)
- Reducing O2 saturation (see guidance under Examination/Assessing Vital Signs on this page)
- Pain or pressure in chest
- Decreased oral intake or urine output (dehydrated, needing IV fluids)
- Cold, clammy or pale mottled skin
- New onset of confusion, becoming difficult to rouse, syncope
- Blue lips or face
- Coughing up blood

Other symptoms indicating severe illness, or significant or rapid deterioration including markedly increased fatigue if O2 Sats are not available *see Managing Progressive Life Limiting Conditions (COVID and non COVID)

The patients risk factors for more severe illness should be considered in making the decision to refer to ED: age (>65), comorbidities as above, immunocompromised, higher frailty score. In addition inability to self-isolate or lack of support at home may be other reasons to consider ED referral.

Risk Stratification Matrix:

<table>
<thead>
<tr>
<th></th>
<th>Average Risk</th>
<th>Low Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients with any of the safety net flags</td>
<td>Otherwise healthy adults; asymptomatic adults</td>
<td></td>
</tr>
<tr>
<td>Patients with symptom deterioration</td>
<td>Pregnant women</td>
<td>No comorbidities</td>
</tr>
<tr>
<td>Any age with medical comorbidities</td>
<td>No safety net flags</td>
<td></td>
</tr>
<tr>
<td>Age &gt; 60</td>
<td>40-60 years old with no medical comorbidities</td>
<td>Age 1-39 years old with no medical comorbidities</td>
</tr>
</tbody>
</table>

**MONITOR**

Daily for 14 days

MONITOR

Every 2 days x 7 days; then recommend self-monitor for additional 7 days depending on progress

MONITOR

Consider self-monitoring only; check-ins determined by individual patient. (Consider at 7 days)

**NOTE** *patients in the low risk category with increasing symptoms move to the high risk/daily monitoring (including pulse oximeter) category. Asymptomatic patients should have their risk category reassessed if they develop symptoms.*

**NOTE** *In patients with significant fatigue in the low risk category, consider using pulse oximetry to determine this is not due to hypoxia.*

*In patients who required hospitalization, the median time from symptom onset to dyspnea was 5 days. In patient who developed ARDS the median time to onset was 3 days after development of dyspnea (around 8 days after symptom onset).*
Covid-19: remote consultations

A quick guide to assessing patients by video or voice call

Infographic is intended for use in a primary care setting, and is based on data available in March 2020, mostly from hospital settings in China. It will be revised as more relevant data emerges. Modified from a BMJ infographic with permission.

1. **Set up**
   - Prepare yourself and decide how to connect
   - Ask patient to have any available equipment to hand to measure Temp, HR, O2 sats, BP, peak flow

2. **Connect**
   - Make video link if possible, otherwise call on the phone
   - Check video and audio
   - Can you hear/speak to me?
   - Confirm the patient’s identity
   - Name
   - Date of birth
   - Check where patient is
   - Are you right now?
   - If possible, ensure the patient has privacy

3. **Get started**
   - Rapid assessment
   - If they sound or look very sick, such as too breathless to talk, go direct to key clinical questions
   - Establish what the patient wants out of the consultation, such as:
     - Clinical assessment
     - Referral
     - Certificate
     - Reassurance
     - Advice on self-isolation

4. **History**
   - Adapt questions to patient’s own medical history
   - Contacts
     - Close contact with known COVID-19 case
     - Immediate family member unwell
     - Occupational risk group
   - History of current illness
     - Date of first symptoms
   - Most common presentation
     - Cough
     - Fatigue
     - Fever
     - Shortness of breath
   - Cough is usually dry but sputum is not uncommon
   - Up to 50% of patients do not have fever at presentation

5. **Examination**
   - Assess physical and mental function as best as you can
   - Over phone, ask carer or patient to describe:
     - State of breathing
     - Colour of face and lips
   - Over video, look for:
     - General demeanour
     - Skin colour
   - Check respiratory function - inability to talk in full sentences is common in severe illness
   - Temperature
   - Pulse
   - Peak flow
   - Blood pressure
   - Oxygen saturation
   - Interpret self-monitoring results with caution and in the context of your wider assessment

6. **Decision and action**
   - Advise and arrange follow-up, taking account of local capacity
   - Which pneumonia patients to send to hospital?
     - Clinical concern, or more severe symptoms/signs e.g.
       - Temperature >38°C
       - Significant dyspnoea
       - Significant tachycardia
       - New confusion
       - Oxygen saturation ≤94%†
   - Likely COVID-19 but well, with mild symptoms
     - Self-management: Fluids, Acetaminophen only if necessary**
   - Likely COVID-19, unwell, deteriorating
     - Arrange follow up by video or in person. Monitor closely if you suspect pneumonia
   - Relevant comorbidities
   - Unwell and needs admission
     - Ambulance Call ED ahead
   - Reduce spread of virus - follow current self-isolation advice
   - Safety netting
     - If living alone, someone to check on them
   - Maintain fluid intake - 6 to 8 glasses per day
   - Seek immediate medical help for red flag symptoms

**Red flags**
- Severe shortness of breath at rest
- Difficulty breathing
- Pain or pressure in the chest
- Cough or fever
- Pale or mottled skin
- New confusion
- Becoming difficult to arouse
- Rashes or bluish lips or nails
- Little or no urine output
- Coughing up blood
- Other conditions, such as:
  - Neck stiffness
  - Non-blanching rash

* Breaths per minute  † Beats per minute  †† If oximetry available for self monitoring
**see expanded management advice document

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The BMJ

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Clinical Guidelines on Outpatient Management of Patients With COVID-19

Remember that outpatient management of COVID-19 is largely supportive. Most patients recover on their own without the need for hospital resources. However, some patients will require closer monitoring because of disease progression and/or risk factors for more severe disease.

5-10 days after onset of symptoms will be the peak of the disease. At that point, patients will either recover without further intervention or will require further treatment, depending on severity.

Risk Factors for More Severe Disease

Consider more active monitoring and education for the following patients:

- Older age > 60; risk increases with each decade.
- Chronic medical conditions:
  - COPD or other lung diseases
  - Cardiovascular disease
  - Obesity
  - HTN
  - CHF
  - Cerebrovascular disease
  - Renal disease
  - Liver disease
  - Diabetes
  - Immunocompromised conditions, including cancer and cancer treatment
  - Substance use disorders

Discuss timed position changes to improve symptoms in patients with moderate symptoms. See toolkit for more information.

Consider referral to the COVID@Home Halton program for more complex patients or patients with moderate disease for more resources to support caring for patients with COVID-19. Use the usual Home and Community Care referral form for palliative or non-palliative patients. For an example, please look at the information package included in the Primary Care toolkit.

Adapted from

# Symptom Management for COVID-19 for Palliative and Non-Palliative Patients

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Management</th>
</tr>
</thead>
</table>
| Fever (Oral temp above 38deg C)              | - Rest  
- Fluid  
- Over-the-counter antipyretics such as acetaminophen 650-1000 mg po qid  
  o Acetaminophen preferred over NSAIDs because NSAIDs increase risk of cardiovascular disease in viral illnesses. |
| Dehydration (ex., from diarrhea, nausea, vomiting) | - Encourage oral fluid intake.  
- Review and hold medications that could contribute to risk of acute kidney injury  
  o Sulfonylureas  
  o ACE inhibitors  
  o Diuretics  
  o Metformin  
  o ARBs  
  o NSAIDs  
  o SGLT2 inhibitors (“—flozin”)  
- Consider anti-nauseants such as Gravol, Metoclopramide or Ondansetron.  
- Consider sending to hospital if severe dehydration. |
| Cough                                        | - Teaspoon of honey  
- Avoid lying on back (impairs ability to cough).  
- Educate around timed position changes (see instructions below).  
- Consider a limited supply of codeine-containing medications such as hycodan to manage severe cough in the short-term.  
  - Palliative patients:  
    o consider morphine or hydromorphone to manage cough. |
| Dyspnea                                      | - Avoid lying on back. See instructions for timed position changes below.  
- Improve air circulation by opening a window or door. |

**Adapted from**

- Keep room cool.
- Manage comorbid conditions like asthma or COPD. Continue their usual puffers, including inhaled steroids.
- Consider inhaled budesonide on a case-by-case basis to improve dyspnea in mild illness.
  - Budesonide 800 mcg bid x 14 days
- **Palliative patients:**
  - Consider morphine or hydromorphone to manage dyspnea.
  - Consider dexamethasone 6mg po od x 7days.
  - Consider home oxygen through C.Air for SaO2 < 92%. Call the nurse navigator at 289-952-2457 to organize and follow.

### COVID-19 Infection

- Steroids show benefit in patients requiring oxygen.
  - Using steroids in patients not requiring oxygen may increase mortality.
  - **Palliative patients:** Consider dexamethasone 6mg po od x 7days.
- Antibiotics should only be used if suspecting a concomitant bacterial pneumonia and patient is stable enough to manage in the community.
- Managing comorbidities:
  - Continue inhaled steroids if used by patients with asthma and COPD.
  - Continue ACE inhibitors and ARBs for HTN.
  - Immunosuppressants should be reviewed with the patient’s appropriate specialist.
- Ineffective treatments:
  - Hydroxychloroquine with or without azithromycin
  - Ivermectin

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**Adapted from**

Timed Position Changes

Timed position changes will maximize recovery from COVID-19 for patients who have symptoms of cough and/or dyspnea.

Cycle through each position, holding them for 30 minutes to 2 hours.
1. Lying on your stomach.
2. Lying on your right side.
3. Sitting up.
4. Lying on your left side.
5. Lying back on your stomach.

Adapted from
Long-term Complications of COVID-19 a.k.a “Long Haul COVID”

Approximately 10%, possibly more, of patients with COVID-19 suffer long-term complications of the disease.

Mild illnesses may have symptoms lasting more than four weeks. Hospitalized patients may report symptoms for eight or more weeks. Patients who were in the ICU will likely have an even longer recovery.

Long-term symptoms may include:
- Extreme fatigue or decreased exercise tolerance
- Muscle weakness
- Inability to concentrate
- Memory lapses
- Mood changes, including depression and anxiety
- Sleep difficulties
- Headaches
- Paresthesias in upper or lower limbs
- Ongoing respiratory symptoms
- Cardiovascular illnesses including myocarditis, palpitations, CHF
- Clotting disorders, including thrombosis

Consider referral to a COVID-19 Rehab Clinic for multidisciplinary rehabilitation led by a physiatrist of patients with post-COVID complications. A list of these clinics can be found on gtarehabnetwork.ca:

Adapted from
**COVID@Home**

*Tools and Resources Supporting Primary Care Providers*

Ontario Health COVID@Home tools and resources can support primary care providers in the community who wish to remotely monitor their patients who have mild to moderate COVID-19. All efforts to support monitoring COVID-19 patients in the community strive to help ease constraints on the health care system.

<table>
<thead>
<tr>
<th>RESOURCE</th>
<th>INFORMATION</th>
<th>HOW TO ACCESS</th>
</tr>
</thead>
</table>
| COVID@Home Monitoring for Primary Care Community of Practice CoP | Ontario Health (through Health Quality Ontario) has developed a COVID@Home Monitoring Community of Practice for Primary Care. Members will gain access to information about clinical pathways based on best evidence and other tools and resources. | 1. Visit [quorum.hqontario.ca](http://quorum.hqontario.ca).  
2. Sign up to create an account.  
3. Visit the Quorum site and **JOIN GROUP**.  
You will be notified by email when granted access. |
| Ontario Health Resource Toolkit: COVID@Home Monitoring for Primary Care | Supports primary care implementing a remote home monitoring system for COVID-19 patients by providing information on:  
2. Quality improvement building blocks. | Click [here](http://quorum.hqontario.ca) to access Ontario Health’s COVID@Home Resource Toolkit. |
| Mainpro+ Certified Video Primary Care for COVID in the Community | This 1-credit-per-hour online Group Learning program certified for up to 1 Mainpro+® credit. To receive your certificate, contact the FMS team at [fms@ocfp.on.ca](mailto:fms@ocfp.on.ca) after watching the session. | Click [here](http://quorum.hqontario.ca) (scroll down) to access the video. |
| COVID-19: Remote Consultations | Supported by the Ontario College of Family Physicians to provide a quick guide to assessing patients by video or voice call. | Review the [algorithm](http://quorum.hqontario.ca) for remote monitoring for COVID-19 patients. |
| Oxygen Saturation Monitors for your COVID+ patients | As part of the COVID@Home initiative, the Ministry of Health has procured a stockpile of oxygen saturation monitors to be distributed to primary care professionals and teams who wish to provide enhanced monitoring of their COVID-19 positive patients at home. | Click [here](http://quorum.hqontario.ca) to learn more.  
Click [here](http://quorum.hqontario.ca) to complete the Oxygen Saturation Monitor Eligibility and Intake Form to order O2 saturation monitors for your COVID+ patients. |

**For more information**

To be connected with your local COVID@Home program, contact: Michelle Gregory-Brooks [michelle.gregory-brooks@lhins.on.ca](mailto:michelle.gregory-brooks@lhins.on.ca) or Jennifer Tran [Jennifer.tran@lhins.on.ca](mailto:Jennifer.tran@lhins.on.ca).

To find out more about COVID@Home, contact Dave Pearson [dave.pearson@lhins.on.ca](mailto:dave.pearson@lhins.on.ca).
How to Order Oximeters

Oxygen Saturation Monitors for your COVID+ patients
As part of the COVID@Home initiative, the Ministry of Health has procured a stockpile of oxygen saturation monitors to be distributed to primary care professionals and teams who wish to provide enhanced monitoring of their COVID-19 positive patients at home.

Click here to learn more: https://www.ontariofamilyphysicians.ca/tools-resources/covid-19-resources/covid-at-home-02sat.pdf

Click here to complete the Oxygen Saturation Monitor Eligibility and Intake Form to order O2 saturation monitors for your COVID+ patients: https://survey.alchemer.com/s3/6240240/O2-Saturation-Monitor-Survey

If unable to dispense oximeters out of your office, Links2Care has agreed to provide pick up or drop off at their locations below:

- Links2Care Oakville Site
  2030 Bristol Circle, Suite 202
  Oakville, ON, L6H 0H2
  Fax: 905-844-5656
  Ph: 905-844-0252

- Links2Care Georgetown Site
  360 Guelph Street
  Georgetown, ON, L7G 4B5
  Toll Free: 1-866-920-6502
  Fax: 905-873-6195
  Ph: 905-873-6502

Thank you for your cooperation
Patient Education Translated in Various Languages

For information translated in various languages:
If helpful, you may want to include the link below in the toolkit for patient education documents related to COVID@Home monitoring that have been translated into several languages. There are two documents that have been translated:

- COVID-19 Guide for Patients Being Monitored at Home
- Pulse Oximetry Patient Instructions

The website is: https://www.riomix.ca/

- Choose “Log in as Guest” (middle red button)
- Type into the search bar: COVID@Home
- The two documents will pop up. Select “VIEW” on the document you want to see and then all the various language versions will be listed and can be accessed.