# MIDDLESEX-LONDON PARAMEDIC SERVICE
# COMMUNITY PARAMEDICINE REFERAL FORM

1035 Adelaide Street South
London ON, N6E 1R4
Office: 519-679-5466
**Please fax completed referral forms to: 226-270-5532**

Patient Label

Health Care Provider Stamp/Label

**NOTE:** The ***Community Paramedicine Referral Form*** is to be completed by or in consultation with the primary care provider. All referrals MUST be accompanied by a signed ***Primary Care Provider Sign-Off*** form.

## PATIENT INFORMATION

| | | | |
|---|---|---|---|
| Given name: | Surname: | Date of birth: | Gender: |
| Health card: | Version code: | | |
| Address: | City: | Postal code: | |
| Primary phone: | Secondary phone: | | |

## RELEVANT CLINICAL HISTORY *Select all that apply

☐ Asthma ☐ Cognitive Impairment ☐ COPD ☐ CVA ☐ Diabetes ☐ Frailty ☐ Heart Failure ☐ Hypertension
☐ Cancer (*Diagnosis*)**:** ☐ Other:

## REASON FOR REFERRAL *Select all that apply

| | | |
|---|---|---|
| ☐ Chronic Disease Management | ☐ Medical Intervention | ☐ Palliative Care (*PCOT# if applicable*): |
| ☐ Point-of-Care Testing | ☐ Remote Monitoring | ☐ Wound Care |
| ☐ CPLTC Program | ☐ Other: | |

## PATIENT GOALS *Outcome or improvements desired associated with the patient's health

## RISK FACTORS *Any relevant risk factors associated with the patient's health or environment

## PRACTITIONER INFORMATION *Please use contact information to be reached at directly Monday to Friday between 8:00AM-5:00PM

| | | |
|---|---|---|
| Name: | CPSO/CNO #: | ☐ Unattached |
| Phone: | Email: | Fax: |
| Reporting Method: ☐ Email ☐ Phone ☐ Fax | Reporting Frequency: ☐ Weekly ☐ Bi-weekly ☐ Monthly ☐ As needed | |

## REFERRING SOURCE INFORMATION

| | | |
|---|---|---|
| Name: | Designation: | Organization: |
| Primary Phone: | Email: | Fax: |