Community Paramedic Referral Form

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PHONE: 1-844-791-1182

Patient Information		
Last Name	First Name	Initial
Date of Birth (yyyy-mm-dd)	Health Card Number	Gender Male ☐ Female ☐
Address	City	Postal Code
Home Phone	Cell Phone	

Primary Support Provider Information			
Name	Relationship		
Address	City	Province	Postal Code
Phone	Alternate		

Referrer's Information Same as Primary Support Provider ☐	Primary Care Provider Information DAFHT ☐
Name	Name
Organization/Relationship	Address
Phone	Phone

Referral Criteria

Diagnosis

- COPD ☐
- CHF ☐
- Diabetes ☐
- Frequent UTI's ☐

Treatments

- System Navigation ☐
- Remote Patient Monitoring ☐
- Point of Care – blood testing ☐
- Urinalysis ☐
- In home assessment ☐

Comments

Referrer Signature____ Date ______________________________________

Primary Care Provider Informed Date ____________________ Phone ☐ Fax ☐ Email ☐

NOTE: The information contained in this form is confidential. It contains personal health information that is subject to the provisions of the 'Personal Health Information Protection Act, 2004'. This form and its contents should not be distributed, copied or disclosed to any unauthorized persons. If you have accessed this form in error, please contact the owner or sender immediately. All or part information from this referral form may be shared with other agencies to provide appropriate care.