Superior North EMS Community Paramedicine Program Referral Form

Please fax completed forms to (807) 684-2657, Attention: CP Program Coordinator

Patient Information

Surname Name _____ Given Name _____

DOB (dd/mm/yyyy) _____ Gender ☐ Female ☐ Male

Address _____ City _____

Postal Code P0T 2C0 Contact Number _____ ☐ Health Links Patient

Primary Care Provider _____ Contact Number _____

Alternate Contact Name: _____

Alternate Contact Phone: _____ Relationship to Patient: _____

Client History

☐ Angina ☐ Anxiety ☐ Arthritis ☐ Asthma ☐ Cancer ☐ COPD ☐ Depression

☐ Dementia ☐ Diabetes ☐ Heart Failure ☐ Hypertension ☐ Seizures ☐ CVA

☐ Other: _____

Requested Paramedic Intervention

☐ Referral is time sensitive ☐ No ☐ Yes If yes, indicate timeline for visit: _____

Community Health Assessment ☐ 3 lead ECG ☐ 12 lead ECG ☐ Blood Glucometry ☐ Temperature ☐ Falls Risk Assessment ☐ Med Compliance

Chronic Disease Management ☐ CHF ☐ COPD ☐ DM ☐ Care plan attached Notes _____

☐ Other _____

Referring Agency / Physician / Health Care Provider (HCP)

Name _____ Referring Agency Manitouwadge Medical Clinic

Phone 807-826-3251 Fax Number 807-826-1215

Does the HCP require phone consultation after visit? ☐ Yes ☐ No

Frequency of follow-up visits _____

Signature _____ Date _____

CONFIDENTIAL WHEN COMPLETED