

## High Intensity Support at Home Community Paramedic Referral Form

## **Client Information**

Client Name: Client #				
Gender: ☐ Male ☐ Female ☐ Other:		DOB:		
Health Card #:		VC:		
Address: City:		Postal code		
Phone #:	Alt. Phone #			
Email:				
Emergency Contact:		Phone #:		
Has the patient participated in Advanced Care Planning? ☐ Yes ☐ No				
Does this patient have a valid DNR or EDITH plan? ☐Yes ☐No (If yes, please attach a copy)				
DNR: Do Not Resuscitate – Requires a valid DNR Confirmation Fo	rm to be honored.	EDITH: Expected Death In the Home		
*Please attach a current medication record,	medical histor	y, as well as any relevant reports*		
Care Provider Information				
Does this client have a Primary Care Provider?	? 🗆 Yes I	□ No		
Primary Care Provider Name:				
Phone #:		Fax #:		
LHIN Care Coordinator:		Phone #:		
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Risk Factors – Please select any that may ap				
☐ Increased risk of falls (1 fall in 3 months)	☐ Social Is	☐ Social Isolation or Living Alone		
☐ Multiple Co-morbidities (>3)	☐ Cognitiv	☐ Cognitive Impairment		
☐ No Primary Care Provider	☐ Geograp	☐ Geographical Isolation		
☐ No Mode of Transportation	☐ Mobility	☐ Mobility Compromise		
☐ Polypharmacy Issues	☐ No Othe	☐ No Other Support Services		
		☐ Caregiver Strain or Burnout		

☐ Recent Discharge from Hospital	☐ Safety Concerns or Hoarding
☐ Financial Vulnerabilities	☐ Unstable or Precariously Housed
☐ Food Insecurity	☐ Other:
Referral Source Information	·
Name and Professional Designation:	
Organization:	
Date of Referral:	
Phone #:	Fax #:
Reason for Referral – What would you like	e the Community Paramedic to accomplish?
Typical Interactions Will Include:	
☐ Vital Signs and Assessment	☐ Environmental Safety Scan
☐ Medication Compliance	☐ Fall Risk Assessment (TUG Test)
☐ Assessment of Social Connections	☐ Caregiver Support
Other Types of Interventions Available:	
☐ ECG or 12-lead Acquisition	☐ Remote Patient Monitoring
☐ Hospital Discharge Follow Up	☐ Seasonal Influenza Vaccination

☐ Welfare Checks	☐ COVID Testing	
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Client Interaction Summaries will be sent back after the initial visit, and ONLY if any significant issues are found on subsequent visits, unless otherwise requested.

Completed referral forms can be faxed to Haldimand County Community Paramedics @ 365-446-0103

## **Contact Information**

Haldimand County Paramedic Service Community Paramedicine Programs 11 Thorburn St S., Cayuga, ON N0A 1E0

Main: (905)-318-5932 x 6113

Cell (905)-481-2510

Email: communityparamedic@haldimandcounty.on.ca

