MIDDLESEX-LONDON PARAMEDIC SERVICE
COMMUNITY PARAMEDICINE REFERRAL 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.

SECTION I – REFERRAL INFORMATION

REFERRAL CRITERIA *Must check one

☐ LTC Waitlist ☐ LTC Assessed as Eligible ☐ LTC Other ☐ LTC Crisis ☐ Special Circumstances ☐ Palliative

REFERRING ORGANIZATION *Referral form must be sent to the primary care provider for completion prior to submission

Organization:
Email: Phone: Fax:

PATIENT INFORMATION

Is the patient aware of this referral? ☐ Yes ☐ No
Given name: Surname:
Address: City: Postal code:
Date of birth: Age: Gender:
Primary phone: Secondary phone:
Health card: Version code:

RELEVANT CLINICAL HISTORY *Check all that apply

☐ Asthma ☐ Cancer ☐ Cognitive Impairment ☐ COPD ☐ CVA ☐ Diabetes ☐ Heart Failure ☐ HTN ☐ Obesity
☐ Other:
Palliative Diagnosis *(If applicable)*: DNR confirmation: PCOT team:

SECTION II – PRIMARY CARE PROVIDER INFORAMTION

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

Name: OHIP/CPSO/Prof. License No.:
Email: Phone: Fax:

Reporting Method/Frequency:

☐ Email ☐ Phone ☐ Fax ☐ Weekly ☐ Bi-weekly ☐ Monthly ☐ As needed

Remote Patient Monitoring: *(Inclusive of heart rate, SpO2, blood pressure and weight management based on the diagnosis)*

☐ Yes ☐ No

Target Range:

☐ Weight: ☐ SpO2 range: ☐ Last HbA1C with date: ☐ Target BP:

Other Pertinent History: *(CAT score, DNR, EDITH, PPS etc.)*

Primary Care Provider Sign-Off Attached:

☐ Yes