**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 Form to be honored. EDITH: Expected Death In the Home***

***\*Please attach a current medication record, medical history, as well as any relevant reports\****

***Care Provider Information***

|  |  |
| --- | --- |
| Does this client have a Primary Care Provider?   | Yes  No  |
| Primary Care Provider Name:  |  |
| Phone #:  |  | Fax #:  |
| LHIN Care Coordinator:  |  | Phone #:  |

***Risk Factors – Please select any that may apply.***

|  |  |
| --- | --- |
| o Increased risk of falls (1 fall in 3 months)  | o Social Isolation or Living Alone  |
| o Multiple Co-morbidities (>3)  | o Cognitive Impairment  |
| o No Primary Care Provider  | o Geographical Isolation  |
| o No Mode of Transportation  | o Mobility Compromise  |
| o Polypharmacy Issues  | o No Other Support Services  |
| o Frequent 911 calls / ED visits  | o Caregiver Strain or Burnout  |
| o Recent Discharge from Hospital  | o Safety Concerns or Hoarding  |
| o Financial Vulnerabilities  | o Unstable or Precariously Housed  |
| o Food Insecurity  | o Other:  |

***Referral Source Information***

|  |  |
| --- | --- |
| Name and Professional Designation:  |  |
| Organization:  |  |
| Date of Referral:  |  |
| Phone #:  | Fax #:  |

***Reason for Referral – What would you like the Community Paramedic to accomplish?***

|  |
| --- |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |

***Typical Interactions Will Include:***

|  |  |
| --- | --- |
| o Vital Signs and Assessment  | o Environmental Safety Scan  |
| o Medication Compliance  | o Fall Risk Assessment (TUG Test)  |
| o Assessment of Social Connections  | o Caregiver Support  |

***Other Types of Interventions Available:***

|  |  |
| --- | --- |
| o ECG or 12-lead Acquisition  | o Remote Patient Monitoring  |
| o Hospital Discharge Follow Up  | o Seasonal Influenza Vaccination  |
| o Welfare Checks  | o COVID Testing  |

***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***

 ***Office (905)-318-5932 x 6113 or Cell (905)-481-2510.***

 ******

***Contact Information***

Haldimand County Paramedic Service

Community Paramedicine Programs

11 Thorburn St S., Cayuga, ON N0A 1E0 Main: (905)-318-5932 x 6113

Email: communityparamedic@haldimandcounty.on.ca