**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?***

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***Typical Interactions Will Include:***

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| --- | --- |
| 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.***

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***Contact Information***

Haldimand County Paramedic Service

Community Paramedicine Programs

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Email: communityparamedic@haldimandcounty.on.ca