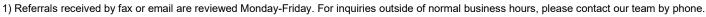
HQPS Community Paramedic Referral Form (V6-2022)

Phone: 613-771-9366, ext. 300 • 1-866-794-7367, ext. 300

Email: communityparamedic@hastingscounty.com

Fax: 1-888-850-9759



2) Illegible and/ or incomp	olete documentation will be return	ned to sender v	vithout action. Pleas	e include all applicable attachments.

Client Information (All Fields Mandatory)	The returned to serider without action. Please include	
Surname:	Given Name:	
Address:	City:	Postal Code:
D.O.B. (mm/dd/yyyy):	☐ Male ☐ Female ☐ X-O	ther Phone:
Health Card # (V/C):	Primary Care Provider:	
MD Office Phone:	Office Fax:	PCP CPSO #:
Substitute Decision Maker / Alternate Contact	t (If applicable)	
Name:	Phone:	
Relationship to Client:		
Referral Information (Select one or more of th	ne following criteria)	
\Box Patient is registered to a Primary Care Prov	rider (MD, NP, PA, etc.)	
and requires additional in-home manageme	ent of CHF AND/OR COPD AND/OR Diabetes AND/C	OR Palliative Care.
$\hfill\square$ Patient is NOT registered to a Primary Care	Provider (MD, NP, PA, etc.)	
and requires a post-exacerbation follow-up	of CHF AND/OR COPD AND/OR Diabetes AND/OR	Palliative Care.
$\hfill\square$ Patient is registered to a Palliative Care Pro	ovider – Provider contact name and phone number:	
$\hfill\square$ Patient is on an LTC waitlist and requires in	home assessment / continued assistance to remain i	independent prior to placement.
$\hfill\Box$ Emergency Department - Sudden increase i	n ED visits / 911 activations in last 30 days (# of visits	s)
$\hfill \square$ In-Patient Unit - Pre-planning required with	Community Paramedic Program prior to submission	(call phone number above, services vary).
$\hfill \square$ Blood Work - Patient is <code>HOMEBOUND</code> with	socioeconomic barriers limiting use of paid in-home	services. Requisition to be attached.
\square POC INR (Roche CoaguChek / Abbott i-STAT)) - Acceptable INR Range: Testing Fre	quency:
number to the Community Paramedic Program agency is responsible for notifying the Communi	nt or new Warfarin prescription to qualify for in-home POC I to ensure timely reporting of results. Documentation will b ty Paramedic Program of all changes to client specific INR t , CHEM8) - Homebound Community Paramedic Prog	be sent to the referring agency post visit. The referring esting protocols.
$\hfill \Box$ OTN eVisit — Scheduled in advance and	facilitated by a Community Paramedic. Comprehe	ensive physical assessment completed prior to
appointment. Reserved for current Communi	ity Paramedic Clients to assist PCP's and Specialists to	o better manage complex care.
\square Urinalysis (Reagent AND/OR Specimen Coll	ection - requisition required as attachment)- Home	bound patients with suspected UTI.
_	up and monitoring provided by the HQPS Community Paranle, Thermometer, and Glucometer available)	nedic Program.
Referring Agency Notes: (Barriers to care, pets in	n home, multimorbidity, polypharmacy, substance abus	se, aggressive behavior, etc.)
Referral Information (All Fields Mandatory)		
Referring Agency:	Phone:	Fax:
Point of Contact:	Email:	
Attachments		
	cation List (Mandatory) Discharge Summary, if applica	able
☐ Other (Client update, PCP correspondence, requ	est for information, virtual / phone appointment requests, p	rogram inquiries, etc.)
		SUPPORTING PEOPLE
Number of Pages Attached:		llasting or