

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

1) Referrals received by fax or email are reviewed Monday-Friday. For inquiries outside of normal business hours, please contact our team by phone.
2) Illegible and/ or incomplete documentation will be returned to sender without action. Please include all applicable attachments.

Client Information (All Fields Mandatory)

Surname:	Given Name:	
Address:	City:	Postal Code:
D.O.B. (mm/dd/yyyy):	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> X-Other	Phone:
Health Card # (V/C):	Primary Care Provider:	
MD Office Phone:	Office Fax:	PCP CPSO #:

Substitute Decision Maker / Alternate Contact (If applicable)

Name:	Phone:
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Relationship to Client:

Referral Information (Select one or more of the following criteria)

- ☐ **Patient is registered to a Primary Care Provider (MD, NP, PA, etc.)**
and requires additional in-home management of **CHF AND/OR COPD AND/OR Diabetes AND/OR Palliative Care.**
- ☐ **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.**
- ☐ **Patient is registered to a Palliative Care Provider** – Provider contact name and phone number:
- ☐ **Patient is on an LTC waitlist** and requires in home assessment / continued assistance to remain independent prior to placement.
- ☐ **Emergency Department** - Sudden increase in ED visits / 911 activations in last 30 days (**# of visits**)
- ☐ **In-Patient Unit** - Pre-planning required with Community Paramedic Program prior to submission (call phone number above, services vary).
- ☐ **Blood Work** - Patient is **HOMEBOUND** with **socioeconomic barriers** limiting use of paid in-home services. Requisition to be attached.
- ☐ **POC INR** (Roche CoaguChek / Abbott i-STAT) - **Acceptable INR Range:** **Testing Frequency:**
Note - Patient must be **homebound** with a current or new Warfarin prescription to qualify for in-home POC INR. **The referring agency** must provide a direct contact number to the Community Paramedic Program to ensure timely reporting of results. Documentation will be sent to the referring agency post visit. The referring agency is responsible for notifying the Community Paramedic Program of all changes to client specific INR testing protocols.
- ☐ **POC Blood Chemistry** (Abbott i-STAT- CG4+, CHEM8) - Homebound Community Paramedic Program clients requiring POC chemistry for Primary Care/ Specialist assessment.
- ☐ **OTN eVisit** – Scheduled in advance and facilitated by a Community Paramedic. Comprehensive physical assessment completed prior to appointment. Reserved for current Community Paramedic Clients to assist PCP's and Specialists to better manage complex care.
- ☐ **Urinalysis (Reagent AND/OR Specimen Collection - requisition required as attachment)**- Homebound patients with suspected UTI.
- ☐ **Remote Patient Monitoring** - Education, set up and monitoring provided by the HQPS Community Paramedic Program.
(BP Cuff, SpO2 Probe (SP02/HR), Weight Scale, Thermometer, and Glucometer available)

Referring Agency Notes: (Barriers to care, pets in home, multimorbidity, polypharmacy, substance abuse, aggressive behavior, etc.)

Referral Information (All Fields Mandatory)

Referring Agency:	Phone:	Fax:
Point of Contact:	Email:	

Attachments

- ☐ Pertinent Medical History (**Mandatory**) ☐ Medication List (**Mandatory**) ☐ Discharge Summary, if applicable ☐ Lab Requisition (Blood, Urine, etc.)
☐ Other (Client update, PCP correspondence, request for information, virtual / phone appointment requests, program inquiries, etc.)

Number of Pages Attached: