GREATER SUDBURY PARAMEDIC SERVICES
COMMUNITY PARAMEDICINE
Request for Service Form

INTAKE WEEKDAYS 8AM-4PM: 705-674-4455 ext. 1121
FAX: 705-983-5757
EMAIL: CPintake@greatersudbury.ca

GREATER SUDBURY PARAMEDIC SERVICE AREA:

Azilda, Capreol, Chelmsford, Coniston, Copper Cliff, Dowling, Falconbridge, Garson, Hanmer, Levack, Lively, Onaping, Skead, Sudbury, Val Caron, Val Therese, Wahnapitae, Walden, Wanup, Whitefish, Worthington

DISCLAIMER

To ensure referrals are processed in a timely manner, all sections must be completed. Failure to complete all sections will result in delayed processing time or referral being rejected. Fax and email referrals are triaged weekdays 8am to 4pm (excluding holidays).

COMMUNITY PARAMEDICINE PROGRAM SUMMARY:

Community paramedics have additional training beyond the traditional 911 emergency response. They work with other health care agencies to keep patients safe and healthy at home.

Services include but are not limited to:

- A combination of scheduled home visits and urgent/same day visits
- Early access & treatment for non-emergency medical concerns
- In home assessments, diagnostics & interventions supported by oversight physicians
- Disease management & education for common chronic illnesses (COPD, CHF, Diabetes, etc.)
- Remote monitoring (blood pressure, oxygen saturation, etc.)
- Medication review & polypharmacy supports
- Support access to other community and health resources

PATIENT CONSENT FOR REFERRAL

Does the patient consent to Community Paramedicine referral? ☐ YES ☐ NO

PATIENT INFORMATION

Name: _____ Health Card Number: _____
Date of birth: (MM/DD/YYYY) _____ Gender: ☐ Male ☐ Female ☐ Other
Address: _____ City: _____ Postal Code: _____
Patient phone number: _____ Primary language: ☐ English ☐ French ☐ Other

CAREGIVER/ALTERNATE CONTACT INFORMATION

Emergency contact: _____ Relationship to patient: _____
Contact number: _____ Is this the primary contact? ☐ YES ☐ NO

PRIMARY CARE/PHARMACY INFORMATION

Does the patient have a Primary Care Provider (MD, NP)? ☐ YES ☐ NO
Provider name: _____ Provider phone number: _____
Patient's pharmacy: _____ Allergies: _____

LONG-TERM CARE

Is the patient on the Long-Term Care Home waitlist? ☐ YES ☐ NO
Is the patient on the Long-Term Care Home crisis list? ☐ YES ☐ NO

RISK FACTORS (check all that apply)

☐ 1 or more falls in the last 3 months ☐ Multiple comorbidities (>3) ☐ Hearing impairment
☐ Lives alone ☐ Frequent 911 calls ☐ Visual impairment
☐ Homebound ☐ Frequent ED visits ☐ Frailty
☐ Geographic isolation ☐ Recent hospital discharge ☐ Compromised mobility
☐ Other (specify): _____

RELEVANT MEDICAL HISTORY (check all that apply)

☐ Coronary Artery Disease ☐ Alzheimer's Disease ☐ Paraplegia ☐ Diabetes Mellitus
☐ Congestive Heart Failure ☐ Dementia ☐ Quadriplegia ☐ Renal Failure
☐ Irregular Heart Rate ☐ Parkinson's Disease ☐ Multiple Sclerosis ☐ Liver Failure
☐ Hypertension ☐ Seizure Disorder ☐ Arthritis ☐ Mental Health or Addictions
☐ Peripheral Vascular Disease ☐ Stroke ☐ Osteoporosis ☐ Cancer
☐ COPD ☐ TIA ☐ Hip Fracture ☐ Palliative
☐ Asthma ☐ Hemiplegia ☐ Other Fracture ☐ Other (specify below)

BRIEF MEDICAL HISTORY AND RELEVANT DETAILS
*Must be completed for referral to be processed

REASON FOR REFERRAL (What are the goals of care for Community Paramedicine involvement? Any specific services requested?)
*Must be completed for referral to be processed

SUPPORTS IN PLACE (check all that apply)

☐ Home & Community Care Support Services ☐ Reliable caregiver ☐ Access to reliable transportation
☐ Other (specify): _____

SAFETY PRECAUTIONS (check all that apply)

☐ Aggressive behaviour ☐ Bedbugs/pest control issues ☐ Hoarding
☐ Substance abuse ☐ Pets in home ☐ Other _____

PLEASE ENSURE ANY RELEVANT DOCUMENTS ARE ATTACHED

☐ Lab requisition ☐ Physician orders ☐ Medication list ☐ Power of Attorney ☐ DNR

REFERRAL SOURCE INFORMATION

Name + Designation: _____ Organization: _____
Phone Number: _____ Fax Number: _____
Signature: _____ Date: (MM/DD/YYYY)_____