



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, Wahnapiatae, 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
- Lives alone
- Homebound
- Geographic isolation
- Other (specify): _____
- Multiple comorbidities (>3)
- Frequent 911 calls
- Frequent ED visits
- Recent hospital discharge
- Hearing impairment
- Visual impairment
- Frailty
- Compromised mobility

RELEVANT MEDICAL HISTORY (check all that apply)

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

- Ontario Health atHome
- Reliable caregiver
- Access to reliable transportation
- Other (specify): _____

SAFETY PRECAUTIONS (check all that apply)

- Aggressive behaviour
- Substance abuse
- Bedbugs/pest control issues
- Pets in home
- Hoarding
- 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) _____