Referral
Community Paramedic Program

This is a PDF form. You have the option to complete all or parts, electronically. When completed, please print and fax to Huron County Community Paramedic Program.

Please return this form to the Huron County Community Paramedic Program via fax to:

1 855 913 2526

Patient Information

Patient's Name: | Mobile Phone #:

Address: | Postal Code:

Date of Birth: | Health Card #: | Version:

Phone #: | Is patient aware of referral? ☐ YES ☐ NO

Clinical Information ☐ See Attached

Relevant Diagnosis:

Allergies: | Communicable Disease:

Referral Reasons (select all that apply)

- ☐ Physical Assessment
- ☐ Vital Signs Assessment
- ☐ Blood Glucose Assessment
- ☐ Home Safety Scan
- ☐ Falls Risk Assessment
- ☐ Medication Compliance
- ☐ Vision Clarity Assessment
- ☐ Mental Health Assessment
- ☐ 12 Lead / 15 Lead EKG
- ☐ Influenza Vaccination
- ☐ COVID Nasopharyngeal Swab
- ☐ Chronic Disease Management
- ☐ Palliative Care/Crisis (SRK)
- ☐ Other

Comments

Referring Organization Information

Date Sent: | Organization:

Clinician Name: | OHIP/CPSO/Prof. License No.

Phone #:

Fax #

Signature: