

Oxford County Paramedic Services Community Paramedic Referral Form

Please fill out fields, sign and fax to Oxford County Paramedic Service at 519-421-7363



Community Paramedic programs help moderate to severe chronic disease patients and frequent users of 911 to self-manage their conditions, and receive regular monitoring of vitals, health coaching, and physician approved treatment orders.

Patient Demographics:

Legal Name (First, Last):	Preferred Name:	Gender: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> X	
Address:	City:	Province:	Postal:
Primary Physician/Nurse Practitioner:	Primary Contact #:	Secondary Contact #:	
Health Card #:	Version Code:	Date of Birth (MM/DD/YY):	
Emergency Contact Name:	Relation:	Phone number:	

- Has the patient ever been a participant of the Oxford County Community Paramedic Program? Yes No Unsure
- Has the patient ever received Community Paramedicine Remote Care Monitoring or Home & Community Support Services Tele-Monitoring program before? Yes No Unsure
- Does the patient have access to a primary care provider? Yes No .

Eligibility Screening (Select all that apply):

- Patient has agreed to be referred to program **AND**
- Lacks in home support system/requires transitional support for a known period of time _____ (specify) **OR**
- Patient has used 911/ED in past 12 months or is at risk of using 911 or visiting ED because of exacerbations related to the **following** chronic health conditions:

Chronic Health Condition (select all that apply)	
<input type="checkbox"/> CHF (Congestive Heart Failure)	<input type="checkbox"/> UTI (Urinary Tract Infection)
<input type="checkbox"/> COPD (Chronic Obstructive Pulmonary Disease)	<input type="checkbox"/> Out of Range INR
<input type="checkbox"/> DM (Diabetes Mellitus)	<input type="checkbox"/> High Risk for Influenza Complications
<input type="checkbox"/> HTN (Hypertension)	<input type="checkbox"/> Palliative Approach to Care

Patient-Appropriate Program Referral Request: You may choose more than one.

What program are you referring your patient to?	Eligibility Criteria for Program
<input type="checkbox"/> Palliative Approach to Care	<input type="checkbox"/> Comfort care approach with goal to stay in the home
<input type="checkbox"/> High Intensity Support in the Home (HISH)	<input type="checkbox"/> Pt. requiring short term CP/nursing interim waitlist
<input type="checkbox"/> Remote Patient Monitoring (RPM)	<input type="checkbox"/> CHF, COPD, DM, HTN

Additional Information Regarding Referral:

General Health Condition of the patient:

Mobility	<input type="checkbox"/> Full assist <input type="checkbox"/> Partial Assist <input type="checkbox"/> Independent <input type="checkbox"/> Other, specify _____
Cognition	<input type="checkbox"/> No Cognitive Impairment <input type="checkbox"/> Subjective Cognitive Impairment <input type="checkbox"/> Mild Cognitive Impairment <input type="checkbox"/> Dementia
Nutrition	<input type="checkbox"/> Well-nourished <input type="checkbox"/> At risk for malnutrition <input type="checkbox"/> Malnourished

Any additional information that referrer would like to attach with the referral (Select all that apply):

Medication Records Lab reports DNR Orders Previous vital signs trends Other (Please specify below)

Referrer Details:

Clinician Type:	Individual or Organization Name:	Phone:
Date Referral Made:	Address:	Fax:
Billing Number:	Professional ID:	Signature
If the patient is not connected to health care services/referral is not from a PCP, please provide a contact number for referring agency/provider in the event additional information or reporting back is required. _____		

Refer to the chart below if your patient is being referred to remote patient monitoring. Make note of requested parameter changes if you do not agree with the pre-determined template

Community Paramedicine will use the **following default alert thresholds** when monitoring the patient. **If different** alert thresholds are recommended for your patient, please **indicate patient range in the chart** below. When triggered, these alert thresholds will generate a response from Community Paramedicine. In the event that **more than one chronic disease** is being monitored, alerts will be set to trigger at the lower or higher threshold accordingly.

READING ALERT THRESHOLDS FOR MONITORING EQUIPMENT

Alert Thresholds	Changes Required
CHF: <ul style="list-style-type: none"> • Weight gain of 1 kg in 24 hours, 2 kg in 48 hours or 3+ kg in 7 days • SpO2 < 92% • HR < 50bpm or > 110bpm • SBP < 90 mmHg or > 180 mmHg or DBP >110 mmHg 	
DM: <ul style="list-style-type: none"> • BG < 4mmol/l or > 24 mmol/l • BG > 18 mmol/l over 3 consecutive days 	
COPD: <ul style="list-style-type: none"> • SpO2 < 88% • HR < 50bpm or > 110bpm • SBP < 90mmHg or > 180 mmHG or DBP > 110mmHg 	
HTN: <ul style="list-style-type: none"> • SpO2 < 92% • HR < 50 bpm or >110 bpm • SBP < 90 mmHg or > 140 mmHg or DBP > 110mmHg 	

Service Overview

(Non Exhaustive List. Note: Services listed in one section are not necessarily precluded from another)

Palliative Approach to Care:

- Assist with the scheduling of transfers to palliative care units/hospice
- Assist with lifts and transfers
- Provide pharmacological treatment for symptom management
- Completion of EDITH forms in the home and assisting with funeral home arrangements
- I.V. access initiation for MAID

High Intensity Supports in the Home:

- Providing immunizations in the home
- Providing “Gap filling” care for patients waiting to be connected to nursing/other services
- Medication compliance
- I.V. antibiotic
- Phlebotomy

Remote Patient Monitoring:

- Remote monitoring of vitals for patient diagnosed with COPD, CHF, Diabetes, and Hypertension
- Teleconferencing and in person home visits when alerted by biometric data/pt symptoms
- Faxing of longitudinal vital trends to MRP’s and care teams

