



# COMMUNITY PARAMEDIC REFERRAL FORM

ARE THERE ANY SAFETY CONCERNS?

Yes  No

Last Name	First Name
Date of Birth (YYYY/MM/DD)	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Physical Address	Mailing Address
Phone	Cell

Referral Information	Reason for Referral:		
	Diagnosis Relevant to Referral:		
Medical Information	Allergies: <input type="checkbox"/> Yes ( <i>Please Attach List</i> ) <input type="checkbox"/> No <input type="checkbox"/> No Known Allergies		
	Medications ( <i>Please Attach List</i> ):		
	Medical History ( <i>Please Attach List</i> ):		
Available Services	Physician or Designate Orders are required for these services. <i>(Orders must be attached) :</i> <input type="checkbox"/> Wound Care (suture removal) <input type="checkbox"/> Medication Administration <input type="checkbox"/> Urinary Catheterization <input type="checkbox"/> In-Home Blood Components & Products Transfusion		
Orders	Please document dose, route, rate/volume, frequency & duration:		
Available Procedures	Community Paramedic will assess GCS, HR, RR, BP, Temp, SpO2. <input type="checkbox"/> 4/12/15 Lead ECG <input type="checkbox"/> Orthostatic Blood Pressure <input type="checkbox"/> ETCO <sub>2</sub> <input type="checkbox"/> Blood Collection <input type="checkbox"/> Blood Glucose Level <input type="checkbox"/> Urine Collection <input type="checkbox"/> Weight <input type="checkbox"/> Microbiology Collection		
Treatment Schedule	For same day treatment, please contact the program at (941) 744-3951 for availability. Please list visit date(s):		
Physician/ Designate	Name	Signature	Date (YYYY-MM-DD)
	Phone/Pager <i>Indicate phone/page number for direct consultation (if necessary)</i>		Cell
Referring Clinic	Name		
	Phone	Fax	

Completed form may be faxed to (941) 749-3516  
 Please call (941) 744-3951 to confirm referral has been received.

