LCPS Community Paramedicine Referral

Date: _____

Client Profile/Notes to be sent to:

_____

_____

(Primary Care Provider Name & Contact Information including Fax – if applicable)

Patient Information

Patient Name: _____Phone # _____

Patient Address: _____

Patient Notes:

Number of Visits Required/Frequency: _____

Community Paramedicine assessment may include:

☐ Vital Signs	☐ Glucose
☐ Mini Mental Assessment	☐ Medication Compliance
☐ ECG	☐ Wellness Assessment (Head to toe)
☐ Risk Assessment (Trips/Fall)	☐ Environmental Scan
☐ Coaguchek INR	☐ Urine Dip (Biostrip 10)
☐ COVID-19 Swab	☐ Other:

MD/PA/NP/RN Name: _____Signature: _____

Fax referral to 613-205-1016 (secure)

If at any time an acute issue arises or patient status has deteriorated a 911 call will be initiated.