BRANT/BRANTFORD COMMUNITY PARAMEDIC PROGRAM

355 Henry Street, Brantford, ON. Phone 1-877-641-9877, Fax 519-753-3525

Patient Information: **Date:**_____

Patient Name:_____ D.O.B.:_____

Patient Address: _____

Phone #: _____ Health Card #:_____

REFERRAL CRITERIA: Unmanaged or newly diagnosed CHF, COPD, atrial fibrillation, severe unstable blood pressure, unstable cardiac conditions, or diabetic sensor changes. Other conditions may be considered if intermittent monitoring is required to prevent deterioration or hospitalization. All referrals are subject to review and approval.

Reason for referral: (must meet criteria above)

- ☐ Recurrent hospitalization
- ☐ Condition Stabilization
- ☐ Other: _____
- ☐ Medical treatment or testing
- ☐ Remote Home Monitoring
- ☐ Post Discharge Care

Medical HX:

- ☐ CHF
- ☐ A-Fib
- ☐ M.I.
- ☐ Hypo/Hypertension
- ☐ COPD
- ☐ Diabetes
- ☐ Angina
- ☐ C.V.A. / T.I.A.
- ☐ Other Med Hx: _____

Considerations:

- ☐ Infectious Disease
- ☐ Behaviour
- ☐ Unkept residence
- ☐ Other

Details: _____

Contact Person & Phone # (if different from patient):

_____

Primary Care Provider (if different from referring partner):

Name:_____ Phone:_____ Fax:_____

Referring Partner:

Name: _____ Agency:_____

Phone: _____Ext:_____ Fax Number: _____

Signature:_____

Providers: Please include recent relevant documents and/or discharge summaries. Please complete associated Procedure Order Form and/or requisition should you request the Community Paramedic to perform specific treatments for your patient.