MIDDLESEX-LONDON PARAMEDIC SERVICE
COMMUNITY PARAMEDICINE REFERAL FORM

1035 Adelaide Street South
London ON, N6E 1R4
Office: 519-679-5466
Please fax completed referral forms to: 226-270-5532

Patient Label

Health Care Provider Stamp/Label

NOTE: The ***Community Paramedicine Referral Form*** is to be completed by or in consultation with the primary care provider. All referrals MUST be accompanied by a signed ***Primary Care Provider Sign-Off*** form.

PATIENT INFORMATION

Given name:	Surname:	Date of birth:	Gender:
Health card:	Version code:		
Address:	City:	Postal code:	
Primary phone:	Secondary phone:		

RELEVANT CLINICAL HISTORY *Select all that apply

☐ Asthma ☐ Cognitive Impairment ☐ COPD ☐ CVA ☐ Diabetes ☐ Frailty ☐ Heart Failure ☐ Hypertension
☐ Cancer (*Diagnosis*)**:** ☐ Other:

REASON FOR REFERRAL *Select all that apply

☐ Chronic Disease Management	☐ Medical Intervention	☐ Palliative Care (*PCOT# if applicable*):
☐ Point-of-Care Testing	☐ Remote Monitoring	☐ Wound Care
☐ CPLTC Program	☐ Other:	

PATIENT GOALS *Outcome or improvements desired associated with the patient's health

RISK FACTORS *Any relevant risk factors associated with the patient's health or environment

PRACTITIONER INFORMATION *Please use contact information to be reached at directly Monday to Friday between 8:00AM-5:00PM

Name:	CPSO/CNO #:	☐ Unattached
Phone:	Email:	Fax:
Reporting Method: ☐ Email ☐ Phone ☐ Fax	Reporting Frequency: ☐ Weekly ☐ Bi-weekly ☐ Monthly ☐ As needed	

REFERRING SOURCE INFORMATION

Name:	Designation:	Organization:
Primary Phone:	Email:	Fax: