



# Community Paramedic Referral Form

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### Patient Information

Last Name:	First Name:	Initial:
Date of Birth (yyyy-mm-dd)	Health Card Number	Gender Male <input type="checkbox"/> Female <input type="checkbox"/>
Address	City	Postal Code
Home Phone		Cell Phone

### Primary Support Provider Information

Name	Relationship		
Address	City	Province	Postal Code
Phone	Alternate		

### Referrer's Information

### Primary Care Provider Information

Name	Name
Organization/Relationship	Address
Phone:	Phone:

### Referral Criteria

### Comments

Referral Criteria	Comments
<b>Diagnosis</b>	
COPD	
CHF	
Diabetes	
Frequent UTI's	
COVID	
Other	
<b>Treatment</b>	
System Navigation	
Remote Patient Monitoring	
Point of Care Blood testing	
Urinalysis	
In Home Assessment	
COVID Follow-up Swab	

Referrer Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**NOTE:** The information contained in this form is confidential. It contains personal health information that is subject to the provisions of the 'Personal Health Information Protection Act, 2004'. This form and its contents should not be distributed, copied or disclosed to any unauthorized persons. If you have accessed this form in error, please contact the owner or sender immediately. All or part information from this referral form may be shared with other agencies to provide appropriate care.