Community Paramedic Referral Form

FAX: 519-941-2486
EMAIL: communityparamedic@dufferincounty.ca
PHONE: 1-844-791-1182

Patient Information		
Last Name:	First Name:	Initial:
Date of Birth (yyyy-mm-dd)	Health Card Number	Gender Male ☐ Female ☐
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**
Diagnosis		
COPD	☐	
CHF	☐	
Diabetes	☐	
Frequent UTI's	☐	
COVID	☐	
Other	☐	
Treatment		
System Navigation	☐	
Remote Patient Monitoring	☐	
Point of Care Blood testing	☐	
Urinalysis	☐	
In Home Assessment	☐	
COVID Follow-up Swab	☐	

Referrer Signature: _____ Date: _____