

Community Paramedic Response Team Referral

- Fax completed form and supporting documents *(as required)* to

<input type="checkbox"/> Patients in and North of Red Deer	<input type="checkbox"/> Patients South of Red Deer
Fax: 780.735.0421	Fax: 403.776.3835
Call: 1.833.367.2788	Call: 1.855.491.5868
- Call to confirm that your fax has been received; Incomplete referrals will not be processed
- Services and availability may vary by Zone
- Physician must be available to Community Paramedics by phone at the time of treatment**

When does Patient need to be seen? Today ► **For same day treatment, call ahead for availability**
 Date *(yyyy-Mon-dd)* _____

Additional / Follow Up Dates Required *(yyyy-Mon-dd)* _____, _____, _____

Patient Information

Last Name	First Name	Date of Birth <i>(yyyy-Mon-dd)</i>
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Gender	PHN	Phone	Alternate Phone
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Site and/or Address where patient will be for treatment	Is Patient a current client of other care providers? <i>(eg. Home Care)</i> <input type="checkbox"/> Unknown <input type="checkbox"/> No <input type="checkbox"/> Yes, <i>specify</i> _____
Allergies <input type="checkbox"/> No Known Allergies <input type="checkbox"/> List attached	

Goals of Care Designation
 Unknown None R1 R2 R3 M1 M2 C1 C2

Does patient have Central Venous Access Device?
 No Yes ► **Attach catheter insertion record with CVC tip verification**

Referral Information

Reason for Referral *(Include Diagnosis or History relevant to referral)*

Physician Orders *(Include: dose, route, rate/volume, frequency and duration as applicable)*

- _____
- _____
- _____
- _____

► **Attach List of Current Medications and Additional Orders *(if required)***

Tests Required *(Check all that apply)*

Community Paramedics will assess Vital Signs on arrival for all patients *(GCS, HR, RR, Temp, Blood Pressure, SpO₂)*

ETCO₂ JVP Weight Blood Glucose Level

12/15 Lead ECG *(not interpreted by a cardiologist)* Swab/Specimen Collection ► **Attach requisition**

Referral Source

Clinic/Site Name	Clinic/Site Contact Name	Direct Phone	Fax
Physician Name	Direct Phone	Cell	Pager
Signature	Date <i>(yyyy-Mon-dd)</i>	Please consult Physician <input type="checkbox"/> during visit <input type="checkbox"/> after visit	