COMMUNITY PARAMEDIC
Request for Service Form

Client Information:

Name:	Client contact number:
Address:	Client aware of referral? □ yes □ no
	Health Card Number:
	Does the client have a valid DNR? □ yes □ no
Date of Birth:	If yes, please attach validity form.

Referral Source Information:

Name and Professional Designation:	
Organization:	Date of Referral:
Phone Number:	Fax Number:

Does the client have a primary care provider? □ Yes □ No
Primary Care Provider Name: _____
Phone Number: _____ Fax Number: _____

Pertinent client findings will be sent back to the Primary Care Provider, unless otherwise specified.

RISK FACTORS - Please check all that apply

□ Increased Risk of Falls (1 fall in the last 3 months)	□ Social Isolation (no support network)
□ Multiple Co-morbidities (>4)	□ Lives Alone
□ No Primary Care Provider	□ Geographical Isolation
□ No Mode of Transportation	□ Mobility Compromise
□ Polypharmacy Issues	□ No Other Support Services (CCAC etc.)
□ Frequent 911 Calls/ER Visits	□ Caregiver Strain
□ Financial Vulnerability	□ Safety Concerns/Elder Abuse
□ Recent Discharge From Hospital	□ Other: _____

SAFETY PRECAUTIONS - Please check all that apply

□ Aggressive Behavior	□ Bed Bugs	□ Hoarding
□ Substance Abuse	□ Pets in Home	□ Other: _____

ASSISTS/SUPPORTS IN PLACE - Please check all that apply

□ Actively Engaged in Community	□ Financially Stable
□ Does Not Live Alone	□ Foot Care
□ Lives Within <15 Mins Of Town	□ <4 Co-Morbidities
□ Good Mobility	□ Primary Care Provider
□ CCAC	□ Medications Up-To-Date/Blister Packs
□ Reliable Transportation	□ Safe at Home

Reason for Referral:
What is the goal that you would like the Community Paramedic Program to achieve for this client?
_____
_____
_____
_____

If request is URGENT, please call 1-844-860-2778.

Requested Tasks:
What tasks would you like the Community Paramedic to accomplish for this Client?

□ Vital Signs	□ Environmental Safety Scan
□ ECG (12-lead)	□ Physical Assessment (head to toe)
□ Blood Draw (requisition included)	□ Medication Compliance
□ INR (point of care testing)	□ Risk Assessment (trip/fall)
□ INR (blood draw)	□ Quick Screen Mental Scan
□ Other:	

Client Interaction Summaries will be sent back after the initial visit and ONLY if any significant issues are found on subsequence visits, unless otherwise specified.

****PLEASE ENSURE FORM IS FILLED OUT ENTIRELY****

A confirmation notice with a Client Identification Number will be sent upon acceptance into the Community Paramedic Program.
If you haven't received a confirmation notice within one (1) week, please call 1-844-860-2778.

For CPRU Office Use Only	
Internal Triage □ Yellow □ Orange □ Red	Date referral is received:
	Date of initial client contact:

Our toll free phone number is 1-844-860-CPRU (2778)
Our secure Fax line number is **613-432-9064**
Please visit www.cpru.care to find more information.

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