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CLINICAL PRACTICE GUIDELINES

Introduction

The following Community Paramedic Clinical Guidelines are based on current standards of practice for community paramedics treating and monitoring patients.

These guidelines have been produced by the County of Hastings and Renfrew Paramedic Services with guidance from Dr. Kristian Davis.

The following guidelines have been created to guide and support the care provided by Community Paramedics for ongoing episodic and acute care needs of our patients. Based upon the assessment and overall presentation of a patient, the Community Paramedic is authorized to apply these guidelines and delegated acts in concert with all applicable regulations and standards.
CPRU Assessments/Diagnostics

The CPRU has enhanced assessment and diagnostic tools that are routinely used. There are training PowerPoint presentations for all required paperwork. Below is a brief description of our assessments/diagnostics paperwork.

CPRU Request for Service Form
Purpose: A form created so allied health agencies can refer appropriate patients to the CPRU Program. This form creates a clear idea as to why they were referred, what the patient’s goals are, what are the requested tasks, what risk factors apply to the patient and current supports/assists that are already in place.

Patients to consider: All patients must have a completed Request for Service Form.

Frequency to be completed: Once for the initial request for service and PRN for any changes in tasks required/frequency of visits.

CPRU Client Confirmation Notice
Purpose: To notify the referring agencies whether their Patient has been accepted to the program or not. If not accepted, the reason must be documented.

Patients to consider: All patients must have a CP Client Confirmation Notice Completed.

Frequency: CP Client Confirmation Notice is to be completed every time a Request for Service form is received.

CPRU Client Interaction Tracker
Purpose: To monitor the date of visits, the frequency of visits, what tasks are too completed, and whether or not the task was completed. This form is to be secured to the front of every Patient file and is to be replaced as soon as it fills up. This form has space to include contact information for the Patient and their Primary Care Provider. This form is a helpful resource to quickly identify fax numbers for physicians when faxing Client Interaction Summaries to them.

Patients to consider: All patients must have a Client Interaction Tracker secured to the front of their file.

Frequency: A Client interaction tracker must be completed when a patient is initially referred to the program and must be replaced when the form is filled out entirely.
**CPRU Client Consent Form**

*Purpose:* The client consent form is used to gain the Patient’s consent for the CPRU program to keep, access and share their medical documents with Allied Health Agencies when appropriate.

*Patients to consider:* All patients must have a signed and completed consent form.

*Frequency:* This form must be completed on the first home visit. It does not need to be completed more than once.

**CPRU Client Profile**

*Purpose:* The Client Profile is used to create an initial idea of the Patient’s general health during the first home visit. From the initial visit onward, any changes in the Patient’s health must be documented in their ongoing paperwork, thus, there is a clear picture of how their health has progressed from when they started with the program to present. This form also includes information regarding their emergency contact, medications, allergies, activities of daily living, support already in place, etc.

*Patients to consider:* A Client Profile must be completed for all patients.

*Frequency:* The Client Profile needs to be completed at the first home visit and does not need to be completed more than once.

**Client Progress Notes**

*Purpose:* Client Progress notes are used to provide a small summary of any changes/abnormalities found in the recent visits. This form is helpful when it is displayed in a viewable location on the inside of the file.

*Patients to consider:* All patients must have a client progress note form easily viewable in their form.

*Frequency:* Client progress notes should be filled in after each visit. The form should be replaced when full.

**Client Interaction Summary**

*Purpose:* To provide information and findings gathered from each home visit. Any chief complaints, medication changes, physical assessment findings, vital signs, tasks completed, referrals or education provided should be documented on this form. Any significant changes in the patient condition should be noted on this form and should be faxed to the patient’s primary care provider.

*Patients to consider:* A Client Interaction Summary must be completed every visit.
Frequency: A Client Interaction Summary should be completed every visit.

**Point of Care INR Test Results**

Purpose: To provide a platform in which a CPRU medic is to record a Patient’s INR reading when tested with the Coaguchek. The Patient’s date of birth, current dosage of Warfarin, INR reading, and recent changes in medications must be documented. This form, regardless of reading, must be faxed to the patient’s physician.

Patients to consider: All patients who were referred to the program for POC INR testing and have an INR requisition on file.

Frequency: This paperwork is to be filled out each time an INR is taken. This can be a recurring requisition or on a PRN basis.

**Fax Cover Sheet**

Purpose: A cover sheet when notifying the appropriate Health Agencies of medical updates on their respective patients when appropriate.

Patients to consider: Any patient who’s information needs to be faxed to their health care provider.

Frequency: Each time something is being faxed.

**Medication Compliance Sheet**

Purpose: To provide a platform for recording how compliant the Patient is being with their medications. This allows the Paramedic to elaborate as to whether they believe the patient is capable of properly taking their medications.

Patients to consider: All patients who are suspected to be non-compliant with their medications; any patient who is suspected to have cognitive impairment and is responsible for their own medications; any patient who has multiple pharmacies with multiple physicians prescribing drugs, etc.

Frequency: At any time that the Patient’s cognitive status changes or is suspected to have difficulties with compliance.

*See Appendix A for Medication Compliance Sheet*
Paramedic In-Home Falls Risk Assessment – Postural Hypotension/TUG Assessment

Purpose: To monitor and document the potential for a fall; secondary to symptoms produced by postural hypotension. This form can be used to highlight postural hypotension as a need for a medication adjustment made by their physician. It is also used to monitor and document a patient’s ability to stand, walk, turn and sit in a timely fashion. This form allows for a clear picture to be painted for the physician or health professional who requested it. Any abnormalities when ambulating should be documented on this form.

Patients to consider: Any patient who complains of postural dizziness or is symptomatic upon postural changes, any patient who is being investigated for frequent falls/at risk of falling, any patient identified to be at risk for falls due to postural hypotension.

Frequency: Upon request and repeated as deemed appropriate by the paramedic.

See Appendix B for Paramedic In Home Falls Risk Assessment

General Mental Health Assessment

Purpose: To assess cognitive ability in the geriatric population as well as establish where the patient sits on the Geriatric Depression Scale.

Patients to consider: Any patient with suspected cognitive impairment or depression.

Frequency: It is important to have a baseline to then gauge any changes off of should the client have a physical or cognitive decline.

See Appendix C for General Mental Health Assessment

Community Paramedic Home Safety Scan

Purpose: To complete a comprehensive safety scan with a checklist to highlight potential safety risks in the home.

Patients to consider: All patients referred to the CPRU program.

Frequency: On initial visit and on an as-needed basis.

See Appendix D for Community Paramedic Home Safety Scan

Vision Clarity Scan

Purpose: The in-field Vision Clarity Scan will be used as a tool to identify any unrecognized problems with vision.
Patients to consider: This is purely a reference for us. Any concerns must be forwarded to the client’s health care practitioner or make arrangements for the client to see an optometrist/ophthalmologist.

Frequency: It is important to have a baseline to then gauge any changes off of should the client have a physical or cognitive decline.

**See Appendix E for Vision Clarity Scan**

**Community Paramedic Remote Patient Monitoring (CPRPM)**

The CPRPM program is a free in-home program that allows clients to take their own vital signs on a daily basis. This is a free program for 6 months. Client’s vital signs are remotely transmitted to the IdealLife server where alerts are to be checked daily and followed up by a Community Paramedic.

Any client can be enrolled provided they meet the inclusion criteria, which is:

- a diagnosis or **CHF** and/or **COPD** and/or **Diabetes**
- and one of the following in the previous 12 months:
  - 3 or more 911 calls
  - 2 or more emergency dept. visits
  - 1 hospital admission

*Diabetes has now been included as an independent qualifier.*

Simply complete the CPRPM referral form and leave a note for Kris Love in DocMeIn to complete the install of equipment.

**See Appendix F for CPRPM Referral Form**
PATIENT FREQUENCY AND SEVERITY RISK MATRIX

Overview
Triage guidelines that the county of Renfrew paramedic service as developed assigns a priority to each patient. These priorities have been deemed to be Severe, Significant, Moderate and Low which reflect the stability of the patient based on risk factors, support services and intensity of workload that the patient imparts on the program.

Goal
Prioritize clients based on patient condition and stability, taking into accounts the clients’ risk factors, client support services and intensity of workload.

Purpose
To provide a baseline that establishes patient priority for the purpose of managing the CPRU program in several categories. By establishing a triage system we will be able to

- Define a manageable patient capacity
- Better assist patients based on their individual needs
**Risk Factors**

These are factors that inhibit a patient’s ability to live safe alone and are cause for concern for destabilizing the condition of a patient. Some patients can manage these factors and others can’t. The latter is cause for concern when determining whether these are issues or not.

**Examples**

- Social Isolation
- Lives Alone
- Geographical Isolation
- Mobility Compromise
- Financial Vulnerability
- Increased Risk of Falls
- Multiple Co-morbidities
- Medication Issues
- Safety Concerns
- Caregiver Strains

**Support Services**

Services that are in place that helps to maintain or improve a patient’s quality of life and help to keep a patient stable. These allow patients to function on a day to day basis and receive all the care and necessities that they need.

**Examples**

- CCAC
- Friends/family
- Home Care
- PSW support
- Meals on Wheels
- Regular Physician Checkups
- Transportation
- Respite
The model of care provides details regarding community paramedicine program delivery. This can entail acting in expanded roles and scope of practice in applying paramedic competencies in non-traditional community environments through collaborative or differentiated practice. Community paramedicine programs aim to reduce the number of patients transported to emergency departments either by re-directing them to service providers not located at a hospital or by providing the necessary care in place. (See Figure below)
Intensity of Workload
Refers to the strain to resources that the patient imparts on the CPRU program

Examples

- Frequency of Visits
- Length of Visits
- Travel Time to Patients Location

The Triage Criteria

Severe
Patient’s condition is unstable. Patient needs uninterrupted services. Every effort must be made to see the patient for scheduled visits.

Risk Factors
Patient has multiple risk factors that are not being addressed or are ongoing issues that are contributing to patient not being stable.

Client Support Services
Patient has little to no support at home or support is not adequate which is contributing to unstable patient condition

Intensity of Workload
Patient requires a high frequency of appointments and may be remotely positioned in the county, contributing to long travel times for visits that require one to two hours consultation.

Significant
Patient’s condition is somewhat stable with low risk of aggravation. The patient’s required care/services provided by the CPRU are helping to keep patient stable. Regular ongoing services should be made a priority and every effort should be made to complete scheduled appointment that day, due to threat of destabilizing patient condition.
Risk Factors

Patient has or has potential for risk factors that if not addressed could negatively affect patient condition and has the potential to destabilize a patient's condition.

Client Support Services

Patients' condition is reliant on supports/services that are in place or may require additional resources to remain stable.

Intensity of Workload

Patient requires high frequency of use with easy access (Bi-weekly to monthly visits and is geographically around many other clients) or patients require low frequency of use with difficult access (monthly to bi-monthly visits in geographically isolated areas). Patient requires 45 minutes to 1 hour and 15 minutes per visit.

Moderate

Patient condition is stable. Required service should be completed that day but may be postponed without harm to the patient.

Risk Factors

Patient May have risk factors that are being addressed or have low potential to negatively affect patient condition.

Client Support Services

Patients' supports and services that are in place are contributing factors to patient stable condition. The resources that are in place are adequate to keep patients condition stable.

Intensity of Workload

Patient has low frequency of service use with easy geographical access (Monthly to Quarterly visits). Patient requires 30-45 minutes per visit.
Low

Patient’s needs for assistance are very low or current needs to not require the CPRU services on a regular basis. Pt is stable and can safely miss a scheduled appointment without threat or harm to patient condition.

**Risk Factors**

Patient has few or no risk factors. If patient does have risk factors they have little to no impact on patient condition.

**Client Support Services**

Patients have or may not have support services at home but this has little to no impact on patient condition.

**Intensity of Workload**

Patient requires very few visits annually (one or two) or a phone call is adequate. Patients put little strain on scheduling and day to day operations.
Congestive Heart Failure

Indications
This clinical guideline is intended for patients with a known history and treatment of congestive heart failure, experiencing an exacerbation of their condition.

Conditions
Age: ≥ 18 years
LOA : Unaltered from normal
HR : 60-150 bpm
RR : 12 - 35
SBP: >100 - < 180 or (+/- 30% of normal)Other: Weight gain >1kg < 5kg

Clinical Considerations
• Ascertain past medical history of chronic renal failure and prior history of use of furosemide and nitroglycerin.
• If patient appears to be in severe distress and has:
  o ongoing chest pain,
  o arrhythmias, i.e. new onset irregular heart rate
  o O2 sat <87% or new drop of 5% from normal,
  o acute onset of >5kg weight gain- consider transport to emergency department
• If patient has unaddressed social issue related to personal safety or inability to maintain independence consult primary care practitioner - consider transport to emergency department.

Contraindications
Allergy or sensitivities to Furosemide or Nitroglycerin
• Unable to safely live independently despite effort

Treatment:
Consider Furosemide

If the patient is not currently using furosemide and does not have a past medical history of chronic renal failure, consider;
• Route-PO
• Dose -40 mg
• Dosing Interval- Initial dose at time of assessment. Repeat daily a.m. x 3 days. (PRN)
• Max # of doses- 4

If the patient is currently using furosemide and does not have a past medical history of chronic renal failure, consider;
• Route-PO
• Dose - doubling of previous chronic/prescribed dose (to a max of 200mg)
• Dosing Interval- Initial dose at time of assessment. Repeat daily a.m. x 3 days. (PRN)
• Max # of doses- 4

Past medical history of chronic renal failure
• Consult with primary care practitioner.

Consider Nitroglycerin

Note:
• Generic nitroglycerin patch available in 0.2-0.4-0.6 mg/hr dosages.
• Nitrodur is also available in 0.8 mg/hr.

<table>
<thead>
<tr>
<th>PREVIOUS NITRO USE?</th>
<th>NO</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Route-Transdermal</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dose -0.2mg/hr patch</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dosing Interval- on q a.m./off q p.m. (12 hr duration)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Max # of doses- 4 day total</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Route-Transdermal</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dose -Increase chronic dose by 0.2mg/hr patch</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dosing Interval- on q a.m. /off q p.m.(12 hr duration)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Max # of doses- 4 days total</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Post Treatment Plan
• Return to previous dosing regimen of medication
• Send report of treatment to primary care physician (or alternate medical care provider)

• Follow up monitoring with patient (schedule based on patient need).
• Consult primary care physician or seek alternate medical attention if patient’s condition deteriorates.
**Chronic Obstructive Pulmonary Disease**

**Indications**
This clinical guideline is intended for patients with a known history and treatment of chronic obstructive pulmonary disease, experiencing an exacerbation of their normal baseline condition.

**Conditions**
- **Age:** \( \geq 55 \text{ years} \)
- **LOA:** Unaltered from normal
- **HR:** 60-150 bpm
- **RR:** 12-40
- **SBP:** >100 - <180 (+/- 30% of normal)
- **O2 saturation:** >87% or < 5% drop from normal

**Clinical Considerations**
Consider consulting the patient’s primary care practitioner if the patient has **any** of below;
- Inadequate response of symptoms to outpatient management
- Inability to eat or sleep due to symptoms
- Inability to care for oneself (i.e., lack of home support)
- Uncertain diagnosis
- High risk co-morbidities including;
  - pneumonia,
  - cardiac arrhythmia,
  - heart failure,
  - diabetes mellitus,
  - renal failure, or
  - liver failure

If patient is in severe distress – initiate transportation.

**Contraindications**

**Allergy or sensitivities to:**
- Salbutamol,
- Ipratropium,
- Predinsone,
- Clarithromycin,
- Cefuroxime,
- Trimethoprim/Sulfamethoxazole,
- Doxycycline, Levofloxacin, or Amoxicillin/Clavulanate
Treatment

Consider Oxygen:
- Route-Nasal cannula
- Dose -1-6 L/min (FiO2 24% to 44%) to titrate to O2 saturation of 90 to 94%
- Max duration- 3 days

and;

Consider 100 mcg Salbutamol metered dose:
- Route-MDI
- Dose -1 to 4 puffs
- Dosing Interval- q 1-4 h
- Max # of doses- 8 puffs/ 4 hours and 48 puffs /24 hours for 3 days and;

and;

Consider 20 mcg Ipratropium metered dose:
- Route-MDI
- Dose -2 puffs
- Dosing Interval- q 4 h
- Max # of doses- Max # of doses- 2 puffs/ 4 hours and 12 puffs /24 hours for 3 days

and;

Consider Prednisone:
- Route-PO
- Dose -30 mg in consultation with primary care practitioner or alternate care provider
- Dosing Interval- Daily q a.m.
- Max # of doses- 5 days
Consider Antibiotic

<table>
<thead>
<tr>
<th>Simple Exacerbation</th>
<th>Complex Exacerbation</th>
</tr>
</thead>
<tbody>
<tr>
<td>at least two of these three symptoms —</td>
<td></td>
</tr>
<tr>
<td>o increased dyspnea,</td>
<td></td>
</tr>
<tr>
<td>o increased sputum volume, or</td>
<td></td>
</tr>
<tr>
<td>o increased purulent sputum</td>
<td></td>
</tr>
<tr>
<td>Simple exacerbation and at least one of:</td>
<td></td>
</tr>
<tr>
<td>o ≥4 exacerbations/year</td>
<td></td>
</tr>
<tr>
<td>o Ischemic heart disease</td>
<td></td>
</tr>
<tr>
<td>o Use of home oxygen</td>
<td></td>
</tr>
<tr>
<td>o Chronic oral steroid use</td>
<td></td>
</tr>
</tbody>
</table>

**Route PO**

Dose - (antibiotic selection should be an alternate class to previous use within past 3 months)
- Amoxicillin 500mg PO TID or
- Clarithromycin 500mg PO BID or
- Cefuroxime 500mg PO Q12h or
- Trimethoprim 160mg/Sulfamethoxazole 800 mg PO BID or
- Doxycycline 100mg PO BID (in consultation with primary care practitioner)
  - Dosing Interval- Daily
  - Max: 7 days

- Dose -Levofloxacin 500mg PO Qdaily or Amoxicillin/Clavulanate 500mg PO Q8h in consultation with primary care practitioner
  - Dosing Interval- Daily
  - Max: 7 days

**Post Treatment Plan**
- Return to previous dosing regimen of medication
- Send report of treatment to primary care physician (or alternate medical care provider)
- Follow up monitoring with patient (schedule based on patient need)
- Consult primary care physician or seek alternate medical attention if patient’s condition deteriorates.
Diabetes

<table>
<thead>
<tr>
<th>NIDDM</th>
<th>IDDM</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Hypoglycemia – glucometry less than 4.0 mmol/L</td>
<td>• Hypoglycemia – glucometry less than 4.0 mmol/L</td>
</tr>
<tr>
<td>• Hyperglycemia with glucometry up to 15 mmol/L can be tolerated well until the patient’s medication can be adjusted by their Family Practitioner – efforts should be made to ensure that this occurs within the next week if possible.</td>
<td>• Hyperglycemia - glucometry more than 8.0 mmol/L</td>
</tr>
</tbody>
</table>

**Indications**

This best practice guideline is to be followed for patients with a known history and treatment of diabetes mellitus, experiencing an exacerbation of their condition. (always consider why a patient may have altered blood sugars, such as infections stressors, cardiac events, med non compliance, and or improper med usage, nutrition, GEM).

**Conditions**

**Age:** ≥ 18 years  
**LOA:** N/A  
**HR:** N/A  
**RR:** N/A  
**SBP:** N/A  
**Other:** Ascertian history of increased blood glucose levels and/or signs and symptoms of dehydration.

**Clinical Considerations**

- If patient has an unaddressed social issue related to personal safety or inability to maintain independence consult primary care giver or alternate medical care provider
- If patient does not have clinical improvement with treatment - consider transport to emergency department.
- If patient is in severe distress – initiate transportation.

**Contraindications**

Allergy or sensitivity to Rapid Insulin.
Treatment

Hyperglycemia

Consider IV fluids (follow IV therapy protocol)
- Route-IV
- Dose – consider bolus of 20 ml/kg reassess at every 250 cc for fluid overload, max volume 1 litre over one hour
- Dosing Interval- infusion over 4 to 6 hours on consultation with primary care provider or alternate medical care provider
- Max duration - 3 days

Consider Rapid Insulin:
- Route- Subcutaneous
- Dose - as per Sliding Scale (see below) on consultation with primary care practitioner or alternate medical care provider
- Dosing Interval- with breakfast, lunch, dinner, and bedtime snack
- Max duration- 3 days

Sliding Scale:

Blood glucose targets - Before Meals = 4 to 7 mmol/L - After Meals = 5 to 10 mmol/L

<table>
<thead>
<tr>
<th>Blood Glucose (mmol/L)</th>
<th>Additional Rapid Acting Insulin (units)</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;8.0</td>
<td>0</td>
</tr>
<tr>
<td>8.0-9.9</td>
<td>1</td>
</tr>
<tr>
<td>10.0-11.9</td>
<td>2</td>
</tr>
<tr>
<td>12.0-13.9</td>
<td>3</td>
</tr>
<tr>
<td>14.0-15.9</td>
<td>4</td>
</tr>
<tr>
<td>16.0-19.9</td>
<td>5</td>
</tr>
<tr>
<td>20.0-29.9</td>
<td>6</td>
</tr>
<tr>
<td>&gt;30</td>
<td>Consider transport to ER</td>
</tr>
</tbody>
</table>

- The correction factor used in this sliding scale is 1 unit of insulin for each 2 mmol/L increase in blood glucose over target level.
- This can be modified by the primary care provider or alternate medical care provider to suit individual patients taking into account insulin sensitivity and previous history.
- Patient continues on existing insulin doses with the increases by the sliding scale.
- Rapid acting insulin used only.
- Blood glucose is to be checked before breakfast, lunch, dinner and bedtime snack.
Hypoglycemia

Hypoglycemia – glucometry less than 4.0 mmol/L

Contraindication
Allergy or sensitivity to Glucagon or Hx Pheochromocytoma.

Treatment

<table>
<thead>
<tr>
<th>Weight Range</th>
<th>Dextrose</th>
<th>Glucagon (If IV access not possible)</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;25 kg</td>
<td>0.5g/kg IV (1 ml/kg)</td>
<td>&lt; 25 kg 0.5 mg IM</td>
</tr>
<tr>
<td>&gt;25 kg</td>
<td>25 gm IV (50 ml D50W)</td>
<td>&gt;25 kg 1 mg IM</td>
</tr>
</tbody>
</table>

Post Hypoglycemic treatment - monitor for 1 hour to ensure effective response to treatment and any requirement for further follow up.

Post Treatment Plan
- Return to previous dosing regimen of medication (if applicable)
- Send report of treatment to primary care physician (or alternate medical care provider)
- Follow up monitoring with patient (schedule based on patient need)
- Consult primary care physician or seek alternate medical attention if patient’s condition deteriorates.

Diagnostics

Phlebotomy (Blood draws)
- To be performed as required or as ordered by primary care Physician or alternate medical care provider.
- Blood samples to be delivered by the Community Paramedic to the Laboratory as directed.
- Capillary blood sampling performed as required and available by Community Paramedic

Urinalysis
- Urinalysis to be performed as required and dipped with kits provided.
- Urine samples delivered to Laboratory for culture and sensitivity as directed.
Urinary Tract Infection

Intended use
Using this directive, the Community Paramedic associated with the County of Renfrew Community Paramedic program is able to assess, diagnose, and treat uncomplicated urinary tract infections during home visits.

Eligibility
- Enrolled patient of the County of Renfrew Community Paramedic Program
- Community members under the care of a physician
- >65 years of age

Clinical Considerations
All patients under the care of the Community Paramedic program who are presenting with one or more of the following:
- Dysuria
- Hematuria
- Urgency
- Cloudy or strong smelling urine
- Suprapubic pain or pressure
- New onset lower back pain with unidentified cause
- Rigors with or without unidentified cause
- New onset delirium
- Change in LOC/Lethargy

Exclusion Criteria
- Temperature >38.0 C, vomiting, or presence of costovertebral angle tenderness
- Patient has a history of urinary calculus
- Patient has a history of frequent UTIs (>3 in the last year)
- Acute Delirium

These symptoms are contraindicated due to the likelihood of the infection being an upper UTI (pyelonephritis, etc.), which can be more difficult to treat.

*For patients presenting with the above contraindications, the Community Paramedic obtains history, performs a physical assessment, documents findings and consults with the primary care provider for further direction on patient care in a timely manner.
The Community Paramedic shall:
Acquire an incident history including presenting symptoms, urine characteristics, past history of UTI and treatment, allergies to antibiotics, and kidney function. A blood draw requisition may be required to test EGFR and creatinine clearance.
Obtain a mid-stream urine sample and apply patient label to specimen bottle. Urine sample should then be tested with a chemical reagent strip using aseptic technique.

Assess urine characteristics with sample provided.

Communicate with the patient that they likely have a urinary tract infection if midstream urine specimen reveals presence of leukocytes (more than trace amount) or presence of nitrates (any positive, including trace amount).

Request a lab requisition for urinalysis and culture and sensitivities from the Primary Care Provider.

Treatment:
Early treatment of UTI is important in elderly patients to prevent progressions to systemic infection. Because UTIs are so common in elderly women, it is important to be aware of the treatment options that are most effective in this population. When choosing an antibiotic, please consider:

- Side-effect profile
- Cost
- Bacterial Resistance
- Likelihood of compliance
- Effect of impaired renal function on dosing
- The possibility of an adverse drug reaction (interactions with other medications, age related pharmacokinetics, etc.).

Antibiotics:

Macrobid

- 100mg BID 7-10 days
- Contraindicated in patients who have a creatinine clearance of <60mL/min (known renal insufficiency or failure) or any allergy/sensitivity.
- Approximate Cost is $1.34 per day.
- Resistance for Macrobid in Canada is 21% in nursing homes and approximately 6-8% in other settings.
Amoxicillin

- 500mg TID x 7-10 days.
- Contraindicated for those who have an allergy or sensitivity.
- Approximate cost is $1.03 per day.
- Resistance for Amoxicillin is approximately 40%.

* It is important to consider that Macrobid and Amoxicillin are general antibiotics and may be ineffective against complicated urinary tract infections. Complicated TI patients include those with structural or functional abnormalities such as a urinary obstruction, chronic catheter or spinal cord injury. For these situations, a consult with the patient’s Primary Care Provider is indicated.

** Once the urine tests have been completed, an adjustment in dosage or change in medication may be warranted depending on the type of bacteria present.

Source:
Out-of-Range INR

Intended use
Using this directive, the Community Paramedic associated with the County of Renfrew Community Paramedic program will be capable of completing a point of care INR test, and provide patient care with regards to the result.

Eligibility
- Enrolled patient of the County of Renfrew Community Paramedic Program and requires regular INR testing.
- Community members under the care of a physician.

Clinical Considerations
All patients under the care of the Community Paramedic program who regularly have their INR tested.

Exclusion Criteria
- Patient not currently taking Warfarin.

The Community Paramedic shall:
Acquire a point of care INR test result using the coaguchek device. Therapeutic range for patients with mechanical mitral valves is 2.5-3.5. For most other patients, the therapeutic range is from 2.0 – 3.0 unless stated otherwise by their physician.

For each out-of-range INR value, attempt to identify the cause. See the section attached, “Summary of Common Causes of Out-of-Range INRs”.

The attached document summarizes the common causes for Out-of-Range INRs. With this as a consideration, inquire about the following:

- Current Warfarin Dosage? Inquire about the possibility of having taken a dosage other than the one prescribed.
- Any missed dosages within the last week? Ensure all dosages were taken and suggest strategies to assist in doing so, i.e., calendar to record doses/pill box, etc.
- Any medications being stopped / started recently? Any new change in dosages? This will likely interact with INR.
- Any variances in diet? Ask about new foods or changes in consumption.
- Any changes in alcohol consumption?
- Any changes in general health? Any condition that may affect INR.
Clinical Decision Making:

- Determine whether a one-time change in the dose is all that is required or if a change in the maintenance dose is required or both.

- A change in the maintenance dose should be considered if there are at least two consecutive out-of-range INR values (in the same direction), in a patient with previously stable, in-range INRs and for which there is no identified temporary cause.

- A one-time change in the dose is appropriate for patients in which a transient cause is identified.

- For patients with previously in-range INR values who present with a single slightly out-of-range INR (e.g. INR 0.5 above or below the target range), there are two management options:
  1. Continue current maintenance dose and repeat INR in 1-2 weeks, OR
  2. Make a one-time dose change (increase or hold by ½ to 1 single dose) and resume current maintenance dose. Repeat INR in 1-2 weeks.

- The specific approach is influenced by the magnitude of the out-of-range value, previous experience of similar values in the patient and whether the patient has strong risk factors for thrombosis/stroke or bleeding. **INRs >6.0 must have a blood draw performed for accuracy.**

**This Nonogram serves as a guide and should not replace clinical judgment.**
Summary of Common Causes for Out-of-Range INRs:

Table 1 and Table 2 summarize common causes and management strategies for low and high INRs, respectively.

### Table 1: Common Causes of Low INRs and Management Strategies

<table>
<thead>
<tr>
<th>Common Causes of Low INRs</th>
<th>Management Strategies</th>
</tr>
</thead>
<tbody>
<tr>
<td>MISSED DOSES, NON-COMPLIANCE, or errors in dosing</td>
<td>Review the doses of Warfarin actually taken over the past several weeks&lt;br&gt;Use strategies to improve compliance: pill box, Warfarin pill box or pharmacy-prepared blister packs, Warfarin dosing calendar, patient education, simplify dosing regimen.</td>
</tr>
<tr>
<td>UNDERDOSING</td>
<td>Be aware that under dosing provides less protection against thrombosis but is still associated with bleeding. Bleeding risk is the same with INRs 1.5-2.0 and 2.0-3.0, but risk of thrombosis rises quickly below INR 2.0.&lt;br&gt;Aim for INR 2.5. Aiming for 2.0 will lead to a higher chance of under dosing.&lt;br&gt;Increase the dose according to INR value.</td>
</tr>
<tr>
<td>CHANGE IN DIET/EXERCISE</td>
<td>Day-to-day and week-to-week variation in dietary vitamin K intake commonly results in variability in INR.&lt;br&gt;Do not advise patients to eat less vitamin K-rich foods.&lt;br&gt;Educate patient to maintain a consistent, healthy diet and lifestyle.&lt;br&gt;If INR is low and changes are long-term, increase the Warfarin dose.</td>
</tr>
<tr>
<td>Increased Vitamin K-rich foods (green leafy vegetables, soy, avocado, seaweed) Meal replacement beverages containing vitamin K Increased exercise</td>
<td></td>
</tr>
<tr>
<td>DRUG INTERACTIONS</td>
<td>A change in INR is seen within two weeks of drug initiation.&lt;br&gt;Increase maintenance dose of Warfarin incrementally until stable maintenance dose is established.&lt;br&gt;Educate patient to maintain consistency. Avoid herbal supplements, extremes of “binging” and avoidance.</td>
</tr>
<tr>
<td>Prescription: phenytoin, carbamazepine, barbiturates, rifampin, azathioprine&lt;br&gt;Non-prescription: green tea, ginseng, St. John’s Wort</td>
<td></td>
</tr>
</tbody>
</table>
Table 2: Common Causes of High INRs and Management Strategies

<table>
<thead>
<tr>
<th>Common Causes of High INRs</th>
<th>Management Strategies</th>
</tr>
</thead>
</table>
| **DRUG INTERACTIONS***     | Temporary drug interaction: temporary Warfarin hold or dose reduction.  
Chronic drug interaction: reduce maintenance dose and increase frequency of INR tests until new stable INR is achieved.  
Although many drugs may interact with Warfarin, avoidance of either Warfarin or the interacting drug is usually **not** required**. |
| **ALTERED HEALTH STATES**  |                       |
| Fever, acute illness, diarrhea, reduced food intake | Temporarily reduce the dose and increase the frequency of INR testing until the patient’s health stabilizes. |
| Uncontrolled hyperthyroidism |                       |
| CHF exacerbation            |                       |
| **MALNUTRITION**           |                       |
| (vitamin K deficiency)      | Encourage patient to consume regular meals, including those containing vitamin K. Consider meal replacement beverage.  
Reduce maintenance dose of Warfarin and increase frequency of monitoring |
| **ALCOHOL**                |                       |
| A one-time moderate to large amounts of alcohol (more than 2 drinks) will transiently increase the INR (e.g. weekend party).  
Continue usual maintenance dose. |
| **NON-COMPLIANCE OR ERRORS IN DOSING** | Review the doses of Warfarin actually taken over the past several weeks.  
Use strategies to improve compliance: pill box, Warfarin dosing calendar, patient education, simplify dosing regimen. |

*Most common drugs that can increase INR:  
Antibiotics: sulfamethoxazole/trimethoprim, metronidazole, quinolones (ciprofloxacin, levofloxacin), amoxicillin, erythromycin, clarithromycin, azithromycin  
Azole antifungals: fluconazole, miconazole, voriconazole  
Cardiac drugs: amiodarone, some statins (fluvastatin), fenofibrate  
Acetaminophen >1 g/day  
Levothyroxine dose increases – full effect observed after 4-6 weeks of dose change
Antiplatelet Agents:
Antiplatelet agents (acetylsalicylic acid (ASA), clopidogrel, prasugrel, ticagrelor) and Non-steroidal Anti-Inflammatory Drugs (NSAIDs) significantly increase the risk of bleeding when combined with Warfarin but generally do not change the INR. The indication and clinical necessity of using these agents should be carefully weighed against the increased bleeding risk, and should be avoided unless specifically indicated.

Source:
Point-of-Care Ultrasound

Point of Care Ultrasound (POCUS) is a useful tool in the assessment of a wide variety of patient conditions. POCUS provides the Paramedic a dynamic image and recording of internal structures as an assessment adjunct and provides additional information to support the clinical decision making process.

The use of ultrasound does not substitute for a thorough clinical assessment and the use of all other data available and clinical experience in the formulation of an appropriate treatment and/or transport plan in accordance with the MOHLTC ALS/BLS Patient Care Standards and related Clinical Practice Guidelines as appropriate.

Indications
- Patients who present with signs or symptoms of disease or injury, where the visualization of internal structures could assist in the formulation of an appropriate assessment, referral, consultation, treatment and/or transport plan.

Conditions
- Age: All
- LOA: N/A
- HR: N/A
- RR: N/A
- SBP: N/A

Clinical Considerations
- Assessment of peripheral perfusion in patients experiencing a long term degradation of peripheral blood flow.
- Assessment of pleural effusion, ascites and similar conditions in patients with chronic disease processes that make them susceptible to gradual increases in these conditions. Consider for patients with conditions such as: Congestive Heart Failure and liver disease including portal hypertension.
- Mechanism of injury whereby blunt or penetrating trauma may have caused injury to lungs, heart, abdominal organs, long bones or vasculature.
- Disease mechanisms which may have resulted in acute alteration or failure of the lung(s) (i.e., spontaneous pneumothorax), effusion in the plural cavity, pericardium/myocardium, or into abdominal/retroperitoneal spaces
- Confirmation of renal or biliary calculi
- Assessment of perfusion to extremities
- Fluid volume assessment
- Assessment of cardiac standstill
- Ultrasound guided IV / cannulisation access
- Long bone fracture assessment
- Cardiac wall abnormalities
The performance of an ultrasound assessment must not interrupt care or transportation as per the ALS / BLS Patient Care Standards or related Clinical Practice Guidelines.

**Contraindications**

- Unable to access patient or unable to conduct exam due to environmental factors (cold, rain, lighting etc.).

- Unable to perform ultrasound assessment without impacting overall transport time to definitive care.

The use of point of care ultrasound and image acquisition does not constitute a clinical diagnosis. All patients are to be assessed and treated as per the ALS / BLS Patient Care Standards and related Clinical Practice Guidelines as appropriate. The use of point of care ultrasound is to provide additional confirmatory information for the Paramedic. It is not to be used in isolation as a diagnostic tool in paramedic practice.
**Influenza**

**Intended use**
This clinical practice guideline is intended for patients experiencing possible influenza like symptoms.

**Eligibility**
- Resident of Long Term Care Facility
- Community members under the care of a physician
- >65 years of age

**Clinical Considerations**
Influenza is suspected when the patient is experiencing an acute onset of respiratory illness with fever ($\geq 39^0$ C) and new or worsening cough and with one or more of the following:
- Sore throat
- Joint pain (arthralgia)
- Muscle aches (myalgia)
- Severe exhaustion (prostration) which is likely due to influenza.

In patients 65 years of age or older, fever may not be as prominent, therefore your overall assessment will determine your index of suspicion.

Additional symptoms may include:
- Headache
- Chills
- Loss of appetite
- Fatigue (tiredness)
- Sore throat
- Runny or stuffy nose


**The Community Paramedic shall:**
- Ascertain past medical history and allergies.
- Complete a comprehensive assessment including vital signs and temperature.

If in the Community Paramedic’s clinical judgment the patient is suspected to have contracted influenza, proceed to proceed to testing and treatment.
Testing

Indications
- Patients 65 years or older suspected to have contracted influenza
- Community members under the care of a physician

Contraindications
- None

Treatment
Complete one of the following tests for influenza confirmation:
- Naso-pharyngeal specimen collection, or
- Point of Care Immunoassays Influenza Test
- Blood Draw

If influenza is suspected or confirmed:

Treatment with Anti-virals

Indications
- Patients 65 years or older suspected to have contracted influenza
- Community members under the care of a physician

Conditions
- See table below

Contraindications
- Allergy to Oseltamivir (Tamiflu®) or Zanamivir (Relenza®)
- Zanamivir (Relenza®) cannot be initiated as a treatment option for patients with a history of chronic obstructive pulmonary disease or asthma.
Treatment

- See table below

Prophylaxis and Treatment with Anti-viral

<table>
<thead>
<tr>
<th>Dosage for treatment</th>
<th>Oseltamivir (Tamiflu®)</th>
<th>Zanamivir (Relenza®)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment</td>
<td>75mg twice daily for 5 days for adults; Dose adjustments may be needed if person is known to have renal impairment. See AMMI guidelines.</td>
<td>2 inhalations twice daily (approximately 12 hours apart) for 5 days 5 mg per inhalation</td>
</tr>
<tr>
<td>Prevention</td>
<td>75 mg daily for 10 days for adults (or in an outbreak, until the outbreak is declared over); Dose adjustments may be needed if person is known to have renal impairment. See AMMI guidelines.</td>
<td>2 inhalations once daily for 10 days</td>
</tr>
</tbody>
</table>

Contraindications

- None
- Underlying respiratory condition such as chronic obstructive pulmonary disease or asthma

Product monograph

- [http://www.rochecanada.com/content/dam/roche_canada/en_CA/documents/Research/ClinicalTrialsForms/Products/ConsumerInformation/MonographsandPublicAdvisories/Tamiflu/Tamiflu_PM_E.pdf](http://www.rochecanada.com/content/dam/roche_canada/en_CA/documents/Research/ClinicalTrialsForms/Products/ConsumerInformation/MonographsandPublicAdvisories/Tamiflu/Tamiflu_PM_E.pdf)
- [http://ca.gsk.com/media/535135/relenza.pdf](http://ca.gsk.com/media/535135/relenza.pdf)

NOTES:

1. Checking creatinine clearance and dose adjustments are not required for those who are not known to have renal impairment. For those with known renal impairment, alternative dosing based on creatinine clearance is provided in Table 5 of the AMMI Guidelines [https://www.ammi.ca/Content/Guidelines/Flu%20%28published%20version%29%20FINAL.pdf](https://www.ammi.ca/Content/Guidelines/Flu%20%28published%20version%29%20FINAL.pdf)
2. A second dose of Relenza (10 mg, which is 2 inhalations) should be taken on the first day of treatment whenever possible, provided there is at least 2 hours between doses (based on the product monograph http://ca.gsk.com/media/535135/relenza.pdf)

Source: CDC Influenza Antiviral Medications: Summary for Clinicians
http://www.cdc.gov/flu/professionals/antivirals/summary-clinicians.htm

Dehydration

Indications

- Patients 65 years or older suspected to have contracted influenza
- This clinical guideline is intended for the patient who has suspected or confirmed influenza and is experiencing current systemic dehydration.

Based on assessment of:

- Mucous membranes
- Urine assessment (colour and output)
- Skin elasticity and turgor
- Capillary refill
- Auscultation of lung fields

Conditions

- Resident of Long Term Care Facility
- Suspected or confirmed influenza

Contraindication

- Patients diagnosed with congestive heart failure showing signs of fluid retention.

Treatment

Consider Normal Saline

- Route- IV
- Dose- 10ml/kg
- Dosing Interval- maximum of 1000ml per 12 hour period

NOTE: Auscultation of lungs fields per 250ml
Nausea and Vomiting

Indications

- Patients 65 years or older suspected to have contracted influenza
- This clinical guideline is intended for the patient who has suspected or confirmed influenza and is experiencing current nausea and/or active vomiting.

Conditions

- Resident of Long Term Care Facility
- Suspected or confirmed influenza
- Current nausea and/or active vomiting.

Contraindication

- Allergy to Dimenhydrinate (Gravol®) or other antihistamines.

Treatment

Consider Dimenhydrinate (Gravol®) via intravenous or intramuscular injection.

- Patient < 50 kg Dimenhydrinate (Gravol®) 25 mg IV/IM
- Patient > 50 kg Dimenhydrinate (Gravol®) 50 mg IV/IM
- Dosing Interval- every 4-6 hours
- Maximum Dosing- 600 mg per 24 hour period

Diarrhea

Indications

- Patients 65 years or older suspected to have contracted influenza
- This clinical guideline is intended for the patient who has suspected or confirmed influenza and is experiencing protracted diarrhea.

Conditions

- Resident of Long Term Care Facility
- Suspected or confirmed influenza
- Protracted severe diarrhea

Contraindications

- Dehydration
- Allergy to Loperamide Hydrochloride (Imodium®)
- Tonic water
- Patient taking Gemfibrozil (treatment of hypercholesterolemia)
• Patient taking Quinidine (class I antiarrhythmic)
• Patient taking Quinine (anti-malarial)
• Patient taking Ritonavir (anti-retroviral)
• Patient taking Stomach acid reducers--cimetidine, ranitidine
• Patient taking Antibiotics - clarithromycin & erythromycin
• Patient taking Antifungal medicine - itraconazole & ketoconazole
• Bloody stool

**Treatment**
Consider Loperamide Hydrochloride (Imodium®)

- Route- PO
- Dose- 4mg initial dose
- Dosing Interval- 2 mg subsequent dose after each unformed stool
- Maximum Dosing- should not exceed 16mg per 24 hour period

**Fever**

**Indications**
- Patients 65 years or older suspected to have contracted influenza
- For the patient who has suspected or confirmed influenza and is experiencing fever ≥39°C

**Conditions**
- Resident of Long Term Care Facility
- Suspected or confirmed influenza
- Currently febrile temperature ≥39°C

**Contraindication**

*Acetaminophen (Tylenol®)*
- Allergy
- Liver dysfunction or condition

*Ibuprofen (Advil®)*
- Allergy to NSAIDs
- Asthma without prior Ibuprofen use
- Uncontrolled hypertension (SBP >180 mmHg)
- Renal disease (eGFR < 40)
Treatment
Consider either Acetaminophen (Tylenol®) or Ibuprofen (Advil®)

*Acetaminophen (Tylenol®)*
- Route: PO
- Dose: <50 kg – 500 mg
  >50 kg – 1000 mg
- Dosing Interval: <50 kg every 4 hours prn
  >50 kg every 6 hours prn
- Maximum Dose: 4000 mg per 24 hour period

*Ibuprofen (Advil®)*
- Route: PO
- Dose: <50 kg – 200 mg
  >50 kg – 400 mg
- Dosing Interval: every 4 hours prn
- Maximum Dose: 2400 mg per 24 hour period

Intravenous and Fluid Therapy

**Indications**
Actual or potential need for intravenous medication or fluid therapy

- Age: N/A
- LOA: N/A
- HR: N/A
- RR: N/A
- SBP: N/A
- Other: N/A

**Clinical Considerations:**
- Assess and auscultate for signs of fluid overload prior to administration of IV fluid.

**Contraindications:**
- Signs of fluid overload
Treatment Procedure:

Administer 0.9% NaCL

<table>
<thead>
<tr>
<th>Maintenance Infusion</th>
<th>Fluid Bolus</th>
</tr>
</thead>
<tbody>
<tr>
<td>30-60ml/hr IV/CVAD</td>
<td>20ml/kg</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Infusion Interval</th>
</tr>
</thead>
<tbody>
<tr>
<td>N/A</td>
</tr>
<tr>
<td>Immediate</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Reassess Every</th>
</tr>
</thead>
<tbody>
<tr>
<td>N/A</td>
</tr>
<tr>
<td>250 ml</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Max. volume</th>
</tr>
</thead>
<tbody>
<tr>
<td>2000 ml</td>
</tr>
</tbody>
</table>

Nausea / Vomiting

Indications
- Nausea or Vomiting

Age: N/A
LOA: Unaltered
HR: N/A
RR: N/A
SBP: N/A
Other: N/A

Clinical Considerations:
- Assess for causes of nausea and vomiting.

Contraindications:
- allergy or sensitivity to dimenhydrinate or other antihistamines
- overdose on antihistamines or anticholinergics or TCAs

Treatment Procedure:

Consider dimenhydrinate

<table>
<thead>
<tr>
<th>Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td>&gt; 25 kg to &lt;50 kg</td>
</tr>
<tr>
<td>IV</td>
</tr>
<tr>
<td>25mg</td>
</tr>
</tbody>
</table>
Maximum Dose: 1
Prior to IV administration, dilute dimenhydrinate (concentration of 50mg/1ml) 1:9 with Normal Saline or sterile water. If given IM do not dilute.

**Analgesia**

**Indications:**
- Pain and/or fever

**Clinical Considerations:**
- Assess for the cause and primary source of pain
- Whenever possible, both acetaminophen and ibuprofen should be used together.

**Conditions:**
Age: >18 yrs of age

LOA: N/A
HR: N/A
RR: N/A
SBP: N/A
Other: N/A

**Contraindications:**

<table>
<thead>
<tr>
<th><strong>Acetaminophen</strong></th>
<th><strong>Ibuprofen</strong></th>
<th><strong>Ketoralac</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Acetaminophen use within previous 4 hours</td>
<td>• Ibuprofen or NSAID use within previous 6 hours</td>
<td>• Ibuprofen or NSAID use within previous 6 hours</td>
</tr>
<tr>
<td>• Allergy or sensitivity to acetaminophen</td>
<td>• Allergy or sensitivity to ASA or NSAIDS</td>
<td>• Allergy or sensitivity to ASA or NSAIDS</td>
</tr>
<tr>
<td>• Signs or symptoms of intoxication</td>
<td>• Active vomiting</td>
<td>• Active vomiting</td>
</tr>
<tr>
<td>• Active vomiting</td>
<td>• Current active bleeding</td>
<td>• Current active bleeding</td>
</tr>
<tr>
<td>• Major burns</td>
<td>• Major burns</td>
<td>• Major burns</td>
</tr>
<tr>
<td>• Hx of peptic ulcer disease or GI bleed</td>
<td>• Hx of peptic ulcer disease or GI bleed</td>
<td>• Hx of peptic ulcer disease or GI bleed</td>
</tr>
<tr>
<td>• Pregnant</td>
<td>• Pregnant</td>
<td>• Pregnant</td>
</tr>
<tr>
<td>• Hx cardiovascular disease</td>
<td>• If asthmatic, no prior use of ASA or other NSAIDs</td>
<td>• Hx cardiovascular disease</td>
</tr>
<tr>
<td>• If asthmatic, no prior use of ASA or other NSAIDs</td>
<td>• CVA or TBI in the previous 24 hours</td>
<td>• If asthmatic, no prior use of ASA or other NSAIDs</td>
</tr>
<tr>
<td>• CVA or TBI in the previous 24 hours</td>
<td></td>
<td>• CVA or TBI in the previous 24 hours</td>
</tr>
</tbody>
</table>
Treatment Procedure:

<table>
<thead>
<tr>
<th>Consider Acetaminophen</th>
<th>Consider Ibuprofen</th>
<th>Consider Ketorolac</th>
</tr>
</thead>
<tbody>
<tr>
<td>Route</td>
<td>Route</td>
<td></td>
</tr>
<tr>
<td>PO</td>
<td>PO</td>
<td>IV/IM</td>
</tr>
<tr>
<td>Dose</td>
<td></td>
<td>960-1000mg</td>
</tr>
<tr>
<td></td>
<td></td>
<td>400mg</td>
</tr>
<tr>
<td></td>
<td></td>
<td>30 mg</td>
</tr>
</tbody>
</table>

Maximum Dose: 1

Ibuprofen and Ketorolac not to be administered concurrently

Glossary

LOA: level of awareness
HR: Heart Rate
RR: Respiratory Rate
SBP: Systolic Blood Pressure
O2 Sat: Oxygen Saturation
Point of Care Ultrasound

For paramedics who have received training in the use point-of-care ultrasound from a recognized program.

Purpose
Ultrasound is a useful tool in the assessment of a wide variety of patients both in the acute and non-acute setting. Its ability to provide visualization of internal structures provides additional information into the clinical decision making process. The use of ultrasound does not substitute for a thorough clinical assessment and the use of other data and clinical experience in the formulation of an appropriate treatment/transport plan.

Indications
Patients who present with signs or symptoms of disease or injury where the visualization of internal structures would benefit the formulation of an appropriate treatment and/or transport plan

Conditions
Age: All:

- LOA: N/A
- HR: N/A
- RR: N/A
- SBP: N/A

Clinical Considerations

In the acute setting;

- Mechanism of injury whereby trauma may have caused injury to lungs, heart, abdominal organs or long bones
- Disease mechanisms which may have resulted in acute failure of the lung(s) (spontaneous pneumothorax), effusion in the plural cavity, pericardium/myocardium, or abdominal/retroperitoneal spaces
- Confirmation of renal or biliary calculi
- Assessment of perfusion to extremities
- Fluid volume assessment
- Assessment of cardiac standstill
- Ultrasound guided IV access
- Long bone fracture assessment

In the non-acute setting;

- Tracking of peripheral perfusion in patients experiencing a long term degradation of peripheral blood flow.
• Assessment of pleural effusion, ascites and similar conditions in patients with chronic disease processes that make them susceptible to gradual increases in these conditions. Consider for patients with conditions such as: CHF and liver disease including portal hypertension.

• The performance of an ultrasound assessment should not impact the time required to transport a critically ill patient to definitive care. Most, if not all, ultrasound exams can be conducted while mobile.

Contraindications

• Unable to access patient or unable to conduct exam due to environmental factors (cold, rain, lighting etc).

• Unable to perform ultrasound assessment without impacting overall transport time.
PHLEBOTOMY

Equipment
Needles:
- Butterfly: 21, 23 & 25 G
- Nexiva: 18, 20 & 22 G
- Steel: 21 & 22 G

Tubes:
- Lavender
- Yellow
- Blue
- Red

Tourniquet
Vacutainers
2x2’s

Procedure
- Apply proper PPE
- Clean and select appropriate site.
- Choose appropriate equipment (proper needle, tourniquet if required)
- Prepare sharps container
- Prepare labels (patient name, patient DOB, patient OHIP number, time of blood draw)
- Select and set out order of tubes as they’re to be collected
- Confirm tubes are not expired
- Complete phlebotomy
- Ensure safe disposal of all sharps in a sharps container
- Mix all tubes by gentle inversion (180 degrees). Lavender tubes must be especially mixed slow due to the increased possibility of causing hemolysis.
- Apply labels to tubes, if not already done. Labels must leave the color of the tube and the expiry date of the tube visible.
- Store in vertical position in outside pocket of blood draw kit for expedited transport to closest lab.
- Ensure proper documentation of all attempts (successful and unsuccessful) on Client Interaction Summary form.

Please see picture on next page for further explanation of the phlebotomy procedure.
Transportation

- Rapid transport and short storage times greatly improve the reliability of laboratory results.
- Do not shake tubes.
- All tubes are to be transported in the vertical position (the clotting procedure is accelerated).
- All blood draws are to be at the lab <2 hours from time of collection. Example: potassium that is >2 hours will yield a false elevation and Glucose >2 hours will yield a false decrease in the levels.
Other Considerations/Helpful Hints

- For INR blood draws, DO NOT use butterfly needles unless you prime the line first. Butterfly needles use air volume in the tube and that’s why the line has to be primed.
- To prime a line, attach a blue tube. Once the line is full of blood, discard the used blue tube (which should have a small amount of blood in it).
- INR (blue tubes) have an etched line. The tubes must be filled at or above the etched line because it requires a specific amount of volume.
- Do not leave the tourniquet on patient for greater than 2 minutes as this will cause hemolysis.
- Take the tourniquet off if the vein cannot be found. Wait 5 minutes and then try reapplying the tourniquet.
- You don’t always have to use a tourniquet. It is better for the vein if you do not need a tourniquet as this can cause hemolysis.
- Always use the needle most appropriate for the vein (the biggest size possible). Do not always use the butterfly on all patients. The faster the blood can flow into the tube, the better.
- We currently have 3 styles of vacutainers that we use. Two are disposable, one is not. Pictures to follow. The one that is not disposable needs to be changed at the beginning on each month.
- Please use exercise caution with alcohol swabs when testing for EtOH as this may interfere with results.
- Please see attached LifeLabs Client Specimen Requirement Chart for further information (next page). Note the arrow at the top that says “Order of Draw”. All tubes are to be drawn in that order.
- Yellow tubes can accommodate up to 8 tests per tube.
- There is no harm in drawing an additional tube if you aren’t sure as this allows the labs to have a bit of leeway as well.
- Every tube is beneficial no matter how much blood is in it.
- Be mindful that patient care and medication doses are reflective of our blood draw results.
- When completing a blood draw in the field, you are deemed to be unavailable for first response until that sample has been delivered to a lab.
- Hemolysis is the breakdown of the cells within the blood. Hemolysis renders the sample useless. Please see picture on page 6 of blood samples including a hemolyzed sample.
- It is normal for your blood sample to coagulate and separate.
# County Labs Contact Information

## Renfrew

<table>
<thead>
<tr>
<th>Company</th>
<th>Address</th>
<th>Hours of Operation</th>
</tr>
</thead>
</table>
| Gamma Dynacare                | 500 Raglan St. North 613-432-4543 | Monday – Thursday 0730-1600 hrs  
|                                |                               | Friday 0730-1230 hrs                                        |

## Beachburg

<table>
<thead>
<tr>
<th>Company</th>
<th>Address</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Whitewater Bromley Community Health Center</td>
<td>20 Robertson Drive 613-582-3685</td>
<td>Drop off location only</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Monday - Friday First pick-up is at 1100 hrs</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Monday - Friday Second pick-up is at 1500 hrs</td>
</tr>
</tbody>
</table>

## Barry’s Bay

<table>
<thead>
<tr>
<th>Company</th>
<th>Address</th>
<th>Hours of Operation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gamma Dynacare</td>
<td>507 - 21 St. Francis Memorial Dr. 613-756-5731</td>
<td>Monday – Friday 0800 – 1430 hrs</td>
</tr>
</tbody>
</table>

## Pembroke

<table>
<thead>
<tr>
<th>Company</th>
<th>Address</th>
<th>Hours of Operation</th>
</tr>
</thead>
</table>
| LifeLabs | 425 Cecelia St. 1-877-849-3637 | Monday – Friday 0800 – 1600 hrs  
|         |                               | Every 4th Friday of every month 0800 – 1300 hrs           |
**COMMUNITY PARAMEDIC MEDICATION COMPLIANCE SHEET**

Client Name:__________________________ Date of Visit: ____/____ /____ DOB:____ /____ /____

<table>
<thead>
<tr>
<th>Source</th>
<th>Medication Name</th>
<th>Medication Dosage/Direction/Amount/Frequency</th>
<th>Compliance Y/N</th>
<th>Expired Y/N</th>
</tr>
</thead>
<tbody>
<tr>
<td>P/OTC</td>
<td>Brand/Generic</td>
<td></td>
<td></td>
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<tr>
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</tr>
</tbody>
</table>

**Medication Adherence:**  □ Poor  □ Good  □ Excellent

**System for Managing:** □ Blister Packs/Pharmacy  □ Pill Boxes (Self)  □ Family Help  □ Pill Vial

**Routine/medication Schedule:** ________________________________________________________________

__________________________________________________________________________________________

**Challenges:** ________________________________________________________________
Pharmacy Information:
Name: _____________________________________________________
Address: ___________________________________________________
Phone No. __________________________________________________

During the Home Visit, the Community Paramedic will:
- Cross-check with attached Active Drug List, if available. (Indicate if pt. is no longer taking medications.)
- Add additional over-the-counter medications. (Vitamins, Supplements, etc.)
- Add any prescriptions not already on the Clients file.
- Add any medication concerns to the Clients file. (Please include Eye-Drops, Inhalers, Creams, etc.)
- Remove expired medications with Client consent, to safely dispose of medications at a local Pharmacy.

Please indicate the expired medications removed: ________________________________________________
________________________________________________________________________________

Client signature authorizing removal of expired medications: _________________________________

Pharmacist signature and designation upon acceptance: _____________________________________
Delivered to and location: ______________________________________________________________

COMMUNITY PARAMEDIC NOTES:
__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________

☐ Medication Compliance Form added to Patient chart. ☐ Send to Pharmacist for review.

Community Paramedic Name: ____________________________________________________________
Timed Up and Go (TUG) Practice Guidelines

TUG test is a screen for general mobility (strength and balance). This test provides a measure of the functional ability of older adults and should be conducted for all new clients and repeated at times of change in health status or after a fall, as well as on annual reassessment. This form can be used for both initial assessment and re-assessment.

For consistency across repeated tests it is important to use similar equipment, therefore, please note the type of chair used and any features of the chair that need to be considered in future tests, e.g., client’s favorite blue arm chair in the living room. This test can also be conducted in a corridor or other common area with a standard chair used for all clients.

Equipment:

- Arm chair
- Tape measure
- Small cone
- Stop watch

Pre-test:

1. Have the client sitting in a chair with arm rests with their back against the back of the chair (chair preferably as close to a 46 cm seat height and 64 cm arm rest height as possible). The chair should be stable and positioned such that it will not move when the subject gets up.

2. Place a cone on the floor 3 meters away from the front of the chair so that it is easily seen by the resident but does not create a trip hazard.

Instructions to the client:

- "On the word GO, stand up and walk at your normal and comfortable pace to the marker on the floor, then turn around and walk back to the chair and sit down”

Guidelines for Clinicians:

1. Demonstrate walking around the cone, without going too far beyond the cone, turning, and walking back.

2. Start timing on the word “GO” and stop timing when the subject is seated again correctly in the chair with their back resting on the back of the chair.

3. The subject wears their regular footwear and may use any gait aid that they normally use during ambulation.

4. There is no time limit. They may stop and rest (but not sit down) if they need to.

5. If the subject is unable to perform the test or unable to perform without being assisted by another person, then do not perform the test and mark the test as “unable to perform”.

6. The subject is allowed a practice trial that is not timed before testing. (The need for the practice trial to be determined by the test administrator).

Time Score Guidelines:

- Most Assisted Living residents take longer than 15 seconds to complete the task.
- A score of 15 seconds or more indicates a higher risk for falling.
<table>
<thead>
<tr>
<th><strong>Date of Initial Test:</strong></th>
<th>(dd-mm-yy)</th>
<th><strong>Time of Day Test Conducted:</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Unable to perform TUG</strong></td>
<td></td>
<td><strong>Arm chair used</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Describe reason:</td>
<td>Describe:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>______________________</td>
<td>______________________</td>
<td></td>
</tr>
</tbody>
</table>

**Mobility aide used:**

- □ No mobility aide used
- □ Cane
- □ Two canes
- □ 2 crutches
- □ Solid Walker – no wheels
- □ Walker – 2 wheels
- □ Walker – 4 wheels
- □ Other: ___________________________

**Observation of Gait & Stability:**

**Guidelines for the clinician:**

Observe how client stands up, with/without using arms; observe stability on turning and any assistance required; observe postural stability, gait pattern and sway; hearing, vision & cognition

**Getting up from Sitting:**

- □ Attempted to get up a few times
- □ Using both arms
- □ Using no/one arm
- □ Other

**Walking:**

- □ Steady
- □ Limping
- □ Dragging the leg
- □ Stiff knees
- □ Other

**Turning:**

- □ Steady
- □ Unsteady
- □ Difficulty moving the walker
- □ Other

**Sitting down:**

- □ Using both arms
- □ Using no/one arm
- □ Near miss of chair
- □ Other

**TUG Score in Seconds:**

- □ Practice
- □ Actual

**Additional Notes**
Postural Hypotension Guidelines

Postural Hypotension is defined as a >20 mmHg drop in systolic or a >10 mmHg drop in diastolic blood pressure upon standing or any symptoms related to blood pressure changes.

Symptoms: dizziness, light-headedness or fainting which may result in a fall.

Symptoms are most severe:
- 30-60 minutes after a heavy meal
- 1-2 hours after taking blood pressure medication
- Dehydration
- Sudden changes in position (getting out of bed, sitting for a while etc).

Points to educate patients on:
- stay well hydrated
- avoid alcohol and caffeinated beverages
- avoid hot baths, reduce the temperature of the bath water
- refrain from any strenuous activity that results in holding your breath or bearing down
- avoid wearing tight belts
- the use of prescription waist-high elastic stockings (minimum 30 mmHg) may be recommended by your doctor
- elevate the head of your bed on blocks by 20-25 cm (8-10”)
- stay active!

Equipment:
- Couch/bed
- Blood Pressure machine/Manual cuff & Stethoscope
- Stop watch

Pre-test:
1. Have the client lay down on a couch or a bed in a comfortable position.
2. Have readily available any assistive devices for when client stands up that they usually use (walkers, cane etc.).

POSTURAL B/P CHECK

<table>
<thead>
<tr>
<th>Lying x 5 Minutes</th>
<th>BP</th>
<th>/</th>
<th>HR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Symptomatic?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Standing x 1 Minute</th>
<th>BP</th>
<th>/</th>
<th>HR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Symptomatic?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Standing x 3 Minutes</th>
<th>BP</th>
<th>/</th>
<th>HR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Symptomatic?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**Generalized Mental Health Assessment**

**Cognitive Assessment**

**A. Orientation**

“What is the year?” _____________

**B. Three-word recall**

Tell the patient: “This is a short memory test. I am going to say 3 words for you to remember and I will ask you to remember them in a few minutes. The 3 words are: table, horse and yellow. Can you repeat them for me?”

**C. Animal generation**

“Now I would like you to name as many animals as you can think of in 1 minute starting now…”

(Write the names down.)

_____________      _____________      _____________      _____________      _____________

_____________      _____________      _____________      _____________      _____________

_____________      _____________      _____________      _____________      _____________

Total # :   ___________      # Repeats :   ___________

**D. Back to 3-word recall**

“Now could you please try to remember the 3 words I said to you?”

__________      ____________     ____________ # Correct:   ___________

**E. Clock drawing**

“Finally, please draw a clock and include all the numbers and the hands on the clock so it shows the time 10 minute after 11?”

Scoring:

- Correct hand placement
- Incorrect hand placement
- Minor spacing problems
- Incorrect number placement

<table>
<thead>
<tr>
<th>Normal (no further assessment needed)</th>
<th>Abnormal (Needs further cognitive assessment)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Animal generation</td>
<td></td>
</tr>
<tr>
<td>□ &gt; 15</td>
<td>□ &lt; 15</td>
</tr>
<tr>
<td>Three-word recall</td>
<td></td>
</tr>
<tr>
<td>□ 2 or 3 correct</td>
<td>□ 0 or 1 correct</td>
</tr>
<tr>
<td>Clock drawing</td>
<td></td>
</tr>
<tr>
<td>□ Normal or mildly abnormal</td>
<td>□ Abnormal</td>
</tr>
</tbody>
</table>

**Depression Scale**

<table>
<thead>
<tr>
<th>Question</th>
<th>□ Yes □ No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Are you basically satisfied with your life?</td>
<td></td>
</tr>
<tr>
<td>2. Have you dropped many of your activities and interests?</td>
<td></td>
</tr>
<tr>
<td>3. Do you feel that your life is empty?</td>
<td></td>
</tr>
<tr>
<td>4. Do you often get bored?</td>
<td></td>
</tr>
<tr>
<td>5. Are you in good spirits most of the time?</td>
<td></td>
</tr>
<tr>
<td>6. Are you afraid that something bad is going to happen to you?</td>
<td></td>
</tr>
<tr>
<td>7. Do you feel happy most of the time?</td>
<td></td>
</tr>
<tr>
<td>8. Do you often feel helpless?</td>
<td></td>
</tr>
<tr>
<td>9. Do you prefer to stay at home, rather than going out and doing new</td>
<td></td>
</tr>
<tr>
<td>things?</td>
<td></td>
</tr>
<tr>
<td>10. Do you feel you have more problems with memory than most?</td>
<td></td>
</tr>
<tr>
<td>11. Do you think it is wonderful to be alive now?</td>
<td></td>
</tr>
<tr>
<td>12. Do you feel pretty worthless the way you are now?</td>
<td></td>
</tr>
<tr>
<td>13. Do you feel full of energy?</td>
<td></td>
</tr>
<tr>
<td>14. Do you feel that your situation is hopeless?</td>
<td></td>
</tr>
<tr>
<td>15. Do you think that most people are better off than you are?</td>
<td></td>
</tr>
</tbody>
</table>

Score: __________ (number of “depressed” answers)

Five or more depressed responses warrants further evaluation.

**Summary**

<table>
<thead>
<tr>
<th>Cognitive assessment score:</th>
<th>Abnormal □</th>
<th>Normal □</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression Scale:</td>
<td>Score: __________</td>
<td></td>
</tr>
</tbody>
</table>

Paramedic Name: ___________________________ Date: ___________________________
# Community Paramedic Home Safety Scan

- **Client Name:** __________  
- **Date of Visit:** ___/___/____  
- **DOB:** ___/___/___

## Home Interior

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stairs inside home are safe</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Handrails on staircases</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Area rugs and carpets safe and secured.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hallways and doorways wide and obstruction free</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adequate heating</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Smoke detectors present and working</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Space heaters safe</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adequate lighting</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adequate plumbing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Absence of rodents/insects</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Walkways clear</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Electrical cords safe</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Furniture arranged to facilitate mobility</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-carpeted floors are not slippery</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Entrances clear and unobstructed</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## Bathroom

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assistive devices installed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anti slip bath mats present</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Toilet aides (commodes or rails)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shower chairs</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## Kitchen

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stove safe and area clear of debris</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kitchen chemicals stored safely</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home Exterior</td>
<td>Yes</td>
<td>No</td>
<td>Comments</td>
</tr>
<tr>
<td>---------------------------------------------------</td>
<td>-----</td>
<td>----</td>
<td>----------</td>
</tr>
<tr>
<td>Walkways cleared</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Able to retrieve mail easily</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ramps present (if needed)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adequate stairs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Snow/Ice removal</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Railing on stairs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adequate lighting</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Exits free of clutter</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No overhanging hazards (ice)</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

Notes:
For the purpose of our assessment, the Snellen Chart (see reverse) will be used as a baseline assessment. Have the client hold the chart at arm’s length and read the letters. Circle the letter or row at which they successfully read without difficulty. It is printed to scale.

<table>
<thead>
<tr>
<th>QUESTIONS</th>
<th>YES</th>
<th>NO</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any known problems with your vision?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Can you read English?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you have an optometrist? If yes, when was the last time you seen them?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>When was the last time you had your eyes tested? (if not at an optometrists i.e at ED, license bureau)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you wear glasses?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Any difficulties reading labels or instructions on medications?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you experience difficulty seeing shadows?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you ever had surgery on your eyes?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Can you see the numbers on your phone?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Can you see the dials on your stove?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Community Paramedic Name: ___________________________ Date: ___________________________
Community Paramedic
Remote Patient Monitoring

CPRPM REFERRAL FORM

Patient Demographics:
Name: ____________________________________________ Date of Birth (mm/dd/yy): ____________________ M/F
Address: __________________________________________ City: __________________________
Home Phone: _______________ Cell Phone: _______________
OHIP #: __________________________ version code: ______

Inclusion Criteria
Diagnosis Of: □ CHF and/or □ COPD
AND one of the following in the previous 12 months:
□ 3 or more 911 Calls
□ 2 or more emergency dept visits
□ 1 hospital admission

Primary Care Provider: ____________________________ □ MD □ NP
Phone: _______________ Secure Fax _______________

We will use the default reading alert thresholds below, unless you indicate otherwise
Signature of Primary Care Practitioner required to alter thresholds

READING ALERT THRESHOLDS

CHF: Weight gain of 1 kg in 24 hours, 2 kg in 48 hours or 3+kg in 7 day
SpO2 < 92%
HR > 110 bpm or < 50 bpm
SBP > 180 mmHg or < 90 mmHg or DBP >110 mmHg

DM: BG > 24 mmol/l or < 4.0 mmol/l (yellow)
BG > 30 mmol/l or < 3.0 mmol/l (red)
BG > 18 mmol/l over 3 consecutive readings

COPD: SpO2 < 88%
SpO2 > 95% if on O2 Therapy
HR > 110 bpm or < 50 bpm (yellow)

Referring Practitioner (MD/PA/NP/RN)
Print Name: ____________________________ Signature: ____________________________
Date: ____________________________ Phone: ____________________________

Fax Request to (613) 647-2778