



Community Paramedic Response Unit
1 844 860-2778

CPRPM REFERRAL FORM

Please fill out fields, sign and fax to Community Paramedic Response Unit at: **613 432-9064**

Patient Information:

Name: _____ DOB (mm/dd/yy): _____ Gender: _____
Address: _____ City: _____ Province: _____ Postal: _____
Home Phone: _____ Cell Phone: _____ Email: _____
OHIP #: _____ Version code: _____

Reason for Referral: CHF COPD Diabetes

Emergency Contact:

Name: _____ Relation: _____ Phone: _____

Primary Care Provider: _____ MD NP Phone: _____

We will use the default reading alert thresholds below, unless you indicate otherwise

READING ALERT THRESHOLDS

CHF: Weight increase of 1 kg in 24 hours, 2 kg in 48 hours
or \geq 3kg in 7 days

*SpO₂ < 92%

*HR > 110 bpm or < 50 bpm

*SBP > 180 mmHg or < 90 mmHg or DBP >110 mmHg

DM: BG 24-30 mmol/l or 3-4 mmol/l (medium)

BG > 30 mmol/l or < 3.0 mmol/l (high)

BG > 18 mmol/l over 3 consecutive readings

COPD: *SpO₂ < 88%

SpO₂ > 95% if on O₂ Therapy

*HR > 110 bpm or < 50 bpm (yellow)

*An alert occurs as a result of 2 consecutive readings outside of these parameters.

Referring Health Provider and Organization: _____

Print Name: _____ Signature: _____

Date: _____ Phone: _____