GREATER SUDBURY PARAMEDIC SERVICES
COMMUNITY PARAMEDICINE
Request for Service Form

INTAKE WEEKDAYS 8AM-4PM: 705-690-5948
FAX: 705-983-5757
EMAIL: CPintake@greatersudbury.ca
CARE TRANSISITONS: 705-923-0729
CP LTC afterhours, nights, weekends: 249-377-7372

GREATER SUDBURY PARAMEDIC SERVICE SERVES:
Sudbury, Onaping, Dowling, Levack, Chelmsford, Azilda, Capreol, Hanmer, Valley East, Val Caron, Wahnapitae, Coniston, Garson, Falconbridge, Skead, Wanup, Worthington, Walden, Whitefish, Lively, Copper Cliff

COMMUNITY PARAMEDICINE PROGRAM REQUESTED [please check box(es)]

☐ CARE TRANSITIONS	☐ LONG-TERM CARE	☐ COVID REMOTE MONITORING
ELIGIBILITY: A primary diagnosis of COPD, CHF, and/or diabetes with multiple hospital admissions or high risk for readmission. Program focus is education and self-management – patients with moderate to severe cognitive impairments are better served by CP Long Term Care Program. **PROGRAM GOALS:** Just in time visits combined with patient education and monitoring to reduce exacerbations and avoid ED visits and hospital admissions. **HOURS:** 7am-7pm, 7 days/week	**ELIGIBILITY:** Seniors who are waiting for LTC in the community, as well as frail elderly who may not be awaiting LTC, but are at risk of failing at home, caregiver burnout, using 911 or ED, or admission potentially resulting in ALC. **PROGRAM GOALS:** A combination of planned and just in time visits to support patients to live safely at home (avoid ED, 911, ALC). **HOURS:** this program operates 24 hours/day, 7 days/week	**ELIGIBILITY:** Confirmed or suspected positive COVID-19 **PROGRAM GOALS:** Assessment, supports, and remote patient monitoring of moderate-high risk COVID positive patients in the community. **HOURS:** 7am-7pm, 7 days/week *remote monitoring is also available for non-COVID patients within other CP programs

For all programs, fax completed referral to 705-983-5757
For Care Transitions, if request is urgent please call 705-923-0729 (7am -7pm, 7 days/week)
For LTC, if service request is urgent, please call 705-690-5948 (weekdays 8am-4pm)
or 249-377-7372 (after hours/nights/weekends/holidays) to speak with a paramedic directly.
For COVID Remote Monitoring, follow fax with a text message to 705-919-0265 indicating a referral has been sent

PATIENT CONSENT FOR REFERRAL

Does the patient consent to Community Paramedicine referral? ☐ YES ☐ NO

PATIENT INFORMATION

Name: _____ Health Card Number: _____
Date of birth (MM/DD/YYYY): _____ Gender: ☐ Male ☐ Female ☐ X-Other
Address: _____ City: _____ Postal Code: _____
Patient phone number: _____ Primary language: ☐ English ☐ French ☐ Other
Primary contact person (if different than patient): _____
Contact number: _____ Relationship to patient: _____
Does the patient have a Primary Care Provider (MD, NP)? ☐ YES ☐ NO
Provider name: _____ Provider phone number: _____
Patient's pharmacy: _____ Allergies: _____
On long-term care waitlist (or soon to be eligible)? ☐ YES ☐ NO
Is the patient Crisis Designation? ☐ YES ☐ NO

RISK FACTORS (check all that apply)

☐ Increased risk of falls	☐ Multiple comorbidities		☐ Hearing impairment	
☐ Lives alone	☐ Frequent 911 calls		☐ Visual impairment	
☐ Homebound	☐ Frequent ED visits		☐ Frailty	
☐ Geographic isolation	☐ Recent hospital discharge		☐ Safety concerns	
☐ Compromised mobility	☐ Walker	☐ Wheelchair	☐ Cane	☐ Other

☐ Other (specify): _____

RELEVANT MEDICAL HISTORY (check all that apply)

☐ COPD	☐ CHF	☐ Diabetes	☐ COVID positive
☐ Dementia or Alzheimer's	☐ Other cognitive impairment	☐ Mental health diagnosis	☐ Anxiety
☐ Hypertension	☐ Stroke	☐ Cancer	☐ Palliative

Brief medical history and relevant details:

REASON FOR REFERRAL (What are the goals of care for Community Paramedicine involvement? Any specific services requested?)

SUPPORTS IN PLACE (check all that apply)

☐Home & Community Care Support Services ☐Reliable caregiver ☐Access to reliable transportation

☐ Other (please specify):

SAFETY PRECAUTIONS (check all that apply)

☐ Aggressive behaviour	☐ Bedbugs/pest control issues	☐ Hoarding
☐ Substance abuse	☐ Pets in home	☐ Other

PLEASE ENSURE ANY RELEVANT DOCUMENTS ARE ATTACHED

☐ Lab requisition	☐ Physician orders	☐ Medication list	☐ Power of Attorney

REFERRAL SOURCE INFORMATION

Name + designation: _____ Organization: _____

Phone number: _____ Fax number: _____

Signature: _____ Date: _____

FAX AND EMAIL REFERRALS ARE TRIAGGED WEEKDAYS 8AM-4PM,
FOR URGENT OR AFTER HOUR REQUESTS, PLEASE CALL