Perth County Community Paramedic Referral
Mobile Integrated Health Team

Patient Information:

Is the patient aware of this referral? ☐ Yes ☐ No

Referral Criteria: ☐ Special Circumstances ☐ LTC Waitlisted ☐ LTC Ax. As Eligible ☐ LTC Crisis ☐ Palliative

Patient's Name: ______________________ Health Card Number: ______________________

Date of Birth: ______________________ Version Code: ______________________

Gender: ______________________ Phone Number: ______________________

Address: ______________________ City: ______________________

Postal Code: ______________________

Clinical Information:

Relevant Clinical History (check all that apply):

☐ Diabetes	☐ GERD	☐ Cognitive Impairment	☐ Stroke
☐ Asthma	☐ Arthritis	☐ Depression/Anxiety	☐ TIA
☐ HTN	☐ Cancer	☐ COPD	☐ CHF
☐ CAD			

Diagnosis: ______________________

Allergies: ______________________

Communicable Diseases: ______________________

Reason for Referral (select all that apply):

☐ Physical Ax. / Vital Signs Ax.	☐ Medication Compliance	☐ Blood Draw
☐ Falls Risk Assessment	☐ 12 Lead EKG	☐ INR Screening
☐ Influenza Vaccination	☐ Urinalysis	☐ Weight Monitoring
☐ Chronic Disease Management	☐ MOCA screening	☐ Blood Pressure Monitoring
☐ Wellness Check 1x	☐ Wound Care	☐ IV Access/Infusion

Goals for MIH involvement / Comments:

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Referring Organization Information:

Organization Name: ______________________ Contact Name: ______________________

Telephone Number: ______________________ Fax Number: ______________________

Email: ______________________ OHIP/CPSO/Prof. License No.: ______________________

Referring Physician or Nurse Practitioner Signature: ______________________

Reporting Method:

☐ Fax ☐ Email ☐ Phone

Frequency:

☐ Weekly ☐ Monthly ☐ As needed

Additional Comments:

Please fax completed referral forms to: 519-508-8488