MEDAVIE HEALTH SERVICES

Mobile Integrated Health

Fax

430 Melville Street
Saskatoon, SK S7J 4M2
TEL (306) 975-8808

FAX (306) 975-8834 - ***Saskatoon***
FAX (306) 692-0326 - ***Moose Jaw***
FAX (306) 338-3302 – ***Wadena***

https://medaviewest.ca/about-us/mobile-integrated-health/

To:	**From:** Community Paramedicine
Fax:	**Pages:**
Phone:	**Date:**
Re:	**CC:**

☐ **Urgent** ☐ **For Review** ☐ **Please Comment** ☐ **Please Reply** ☐ **Please Recycle**

- **Comments:**

Saskatchewan Health Authority

EMS Community Paramedicine Services Referral

INITIAL APPLICABLE BOXES

Patient Name: _____
Date of Birth: _____ HSN: _____
Address: _____
City/Town: _____ Postal Code: _____
Gender: ☐ Male ☐ Female ☐ Other – Identifies as: _____
First Nations and Inuit Health Benefit (FNIB) #: _____

The intent of this document is to operate as a fluid referral form between healthcare agencies and EMS.

REFERRAL TO:	**REFERRAL FROM:**
☐ EMS ☐ HC ☐ CPAS ☐ OT ☐ PT ☐ SW ☐ CDM	☐ EMS ☐ HC ☐ CPAS ☐ OT ☐ PT ☐ SW ☐ CDM
☐ Other: _____	☐ Other: _____

☐ **Patient informed of referral process** (required)	Patient Phone Number:
Directions to home:	
Key Contact / alternate contact name:	Number:
Copies included (as applicable): ☐ MAR ☐ Allergy / Intolerance Record ☐ Lab result ☐ Other: _____	

REASON FOR REFERRAL / GOALS FOR TREATMENT / SAFETY CONSIDERATIONS *(Hazards/Precautions/Special Circumstances/Pets/Things to Note)*

LIVES IN

☐ Personal Residence	☐ Long Term Care	☐ Other: _____
☐ Personal Care Home	☐ Senior's Complex	_____

CARE SERVICE REQUEST

☐ Assessment(s)	☐ Palliative care supports	☐ Lift assist
☐ Discharge supports	☐ Phlebotomy/lab sample *(requisition required)*	☐ Pain control
☐ Fall prevention assessment	☐ Wellness check	☐ Blood glucose level
☐ Hydration – *orders for solution, volume, rate and duration of therapy required*	☐ Catheter care	☐ Vital sign monitoring
☐ IV start/re-start	☐ ECG	☐ Wound assessment
☐ Medication administration/assist	☐ Home detox supports	☐ Other: _____
☐ Suture/staple removal	☐ IV medications *(specify below)*	_____
		_____

REQUEST DETAILS *(frequency, time of day, etc. for example: TPR, BP 3x/week, BGL once weekly)*

RELEVANT PAST MEDICAL AND SURGICAL HISTORY

☐ Arthritis	☐ Dementia	☐ Neurodegenerative disease: _____
☐ Asthma/COPD	☐ Diabetes	_____
☐ Cancer	☐ Hypertension	☐ Rheumatic Disease
☐ Cardiovascular disease	☐ Hyperthyroidism	☐ Past injuries:_____
☐ Communicable disease: _____	☐ Hypothyroidism	☐ Stroke
_____	☐ Mental health illness:_____	☐ Surgeries: _____
☐ Chronic musculoskeletal condition:	_____	☐ Other: _____
_____		

CONTACT HEALTHCARE TEAM IF

CONNECTING WITH CARE PROVIDERS	**NAME**	**CONTACT NUMBER**
Most Responsible Practitioner		
EMS contact name and number (if applicable)		
Other clinical team member name and number (as appropriate to patient care needs, such as Home Care, Mental Health, etc.)		

Referring Professional	**Name (print):**	**Date:**
	Signature:	**Designation:**