Saskatchewan Health Authority

EMS & Community Paramedicine Referral Form

The intent of this document is to operate as a fluid referral form between health care agencies and EMS
Please remember to fax the appropriate professional(s)
*Denotes Required Field

Print Reset Form

Date: _____	**Sex:** ☐ Male ☐ Female	Place sticker here (if used)
Surname: _____	**First Name:** _____ **Preferred Name:** _____	
Birth Date (MM-DD-YYYY): _____	**Health Services Number:** _____	
Phone Number: _____	**Address:** _____	**Directions to home:** _____ **Postal Code:** _____

Copy ❒ included or ❒ requested: ❒ MAR ❒ Allergy/Intolerance Record ❒ Lab results ❒ Other: _____

Lives in: ❒ house ❒apartment/condo ❒ assisted living ❒ personal care home ❒ LTC ❒ Other: _____

Lives with: ❒ alone/self ❒ spouse ❒ parent ❒ child ❒ caregiver ❒ friend ❒ family ❒ Other: _____

Referral to: ❒ EMS ❒ HC ❒ CPAS/Bedline ❒ OT ❒ PT ❒ SW ❒ CDM ❒ Other: _____	**Referral From:** ❒ EMS ❒ HC ❒ CPAS/Bedline ❒ OT ❒ PT ❒ SW ❒ CDM ❒ Other: _____

Safety Considerations: Hazards /Precautions/ Special Considerations/Pets/Things to Note

Pertinent Past Medical History

❒ Diabetes	❒ Cardiovascular Disease	❒ Communicable Diseases:_____
❒ Asthma/ COPD	❒ Rheumatic Diseases (e.g. RA/Lupus)	❒ Neurological Degenerative Disease
❒ Mental Illness	❒ Osteoarthritis	❒ Surgeries: _____
❒ Cancer	❒ Chronic Musculoskeletal Condition	❒ Past Injuries:_____
❒ Dementia		❒ Other: _____

Reason for Referral /Goals for Treatment: Assistance to ☐ manage OR ☐ monitor medical conditions

❒ New condition ❒ Chronic condition Describe: _____

❒ **Patient informed of referral process*** ❒ CP Brochure Provided

Care Service Request:

❒ Discharge Supports	❒ Catheter Care
❒ ECG	❒ Dressing Care – Basic
❒ Fall Prevention/Assessment	❒ Hydration – *orders* for *solution, volume, rate, and duration of therapy required*
❒ Pain Symptom Management	❒ IV Antibiotics ❒ 1st Dose ❒ Subsequent Doses
❒ Point of Care Testing – glucose	❒ Medication Assist
❒ Vital Signs Monitoring	❒ Phlebotomy/Lab Services
❒ Wellness Check	❒ Other:
During COVID -19 Pandemic Only ❒ Nasopharyngeal/Oropharyngeal Swab Collection	

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Name: _____ **HSN:** _____

*** Request Details – frequency, time of day, etc.** *(Example: TPR, BP 3x/week; BGM once weekly; BP q2d)*

Comments:

Contact Health Care Team if:

Connecting With Clients/Patients/Residents & Families/Friends

Family/Friends notified of referral(s) if appropriate: ☐ Yes ☐ No If no, why not: _____

Name & relationship of person contacted: _____

Name of person who contacted family (if known): _____ Date:_____

Connecting With Care Providers

***Most Responsible Practitioner Name: _____ *Contact Number:_____**

***Emergency Medical Service (EMS) Name**: _____

*EMS Contact Name: _____ *Contact Number: _____

Health Care Professionals (as appropriate to patient care needs):

Home Care Team Contact Name: _____ Contact Number:_____

Mental Health Team Contact Name _____ Contact Number:_____

Assessor/Coordinator Contact Name: _____ Contact Number: _____

Other – Contact Name: _____ Contact Number: _____

Referral Date: _____

Signature: _____ Employee Name (print): _____

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EMS & Community Paramedicine
Fax Cover Sheet

To: EMS Service / SHA Department:	**Phone Number:** _____ **Fax Number:** _____
From: EMS Service / SHA Department:	**Phone Number:** _____ **Fax Number:** _____
Number of pages (including fax cover):	
Date:	
Re:	

Please see the attached documents:

❒ EMS & CP Referral (SHA 0203)

❒ Other:

Please respond to this fax to ensure this referral has reached the recommended healthcare professional.