HALTON REGION PARAMEDIC SERVICES
Community Paramedicine for Long-Term Care (CPLTC) Referral Form

Name: (first name, last name)	**Birth Date:** (month/day/year)
Address: (include postal code)	**Capacity:** YES ☐ NO ☐ (Please check) **Phone Number (Home):**
Health Card Number (including version code):	**Phone Number (Cell):**
Referring Organization Name:	**Date of Referral:** (month/day/year)
Name: **Phone Number:**	**Has the client consented to this referral?** YES ☐ NO ☐ (Please check)
Primary Care Physician:	**Phone Number:**
Ontario Health at Home – Care Coordinator:	**Phone Number:**
Family/Caregiver/SDM (if applicable):	**Phone Number:**

Inclusion Criteria: (Please check)

- ☐ Currently on the wait list for Long-Term-Care
- ☐ Has been assigned as eligible for LTC by an Ontario Health atHome Care (OHAH) CC (but not yet waitlisted)
- ☐ Soon to be eligible for LTC: Identified as needing or waiting for an OHAH CC to assess eligibility for LTC.

Reasons for Referral (select all that apply):

- ☐ Isolation
- ☐ Falls Risk/Mobility Concerns
- ☐ Chronic Disease Support
- ☐ Routine Injections & Immunizations
- ☐ Point of Care Testing
- ☐ Caregiver Burnout
- ☐ Increased 911/ED Use
- ☐ No Primary Care Provider
- ☐ Stabilization in the Community

Safety Precautions/Hazards
(Select all that apply)

- Violence/Crime ☐
- Hoarding ☐
- Infestation ☐
- Abuse ☐
- Animals ☐
- Other: (detail below)

Other Requested Assessments/Referral Goals: (please specify):

Relevant Clinical History (select all that apply):

- ☐ COPD/Asthma
- ☐ Congestive Heart Failure (CHF)
- ☐ Diabetes
- ☐ Cognitive Impairment
- ☐ Hypertension
- ☐ CVA
- ☐ Failure to Thrive
- ☐ Frequent UTI

Other (please specify):

SUBMIT VIA SECURE FAX TO (905) 825-3853

For CPLTC Medic On Duty Phone: 905-825-1202 Ext. 1 **For Referral Questions/follow up:** 905-825-6000 X 7892