Community Paramedic Physician Referral

Patient Information		
Last Name	First Name	Date of Birth
Gender: ☐ M ☐ F	Phone	Alternate Phone

Address/ Site where Pt will be for visit	Date Patient should be seen: _________________________ Additional/Follow-up – How often? ____________________
Allergies	

Referral Information
Reason for Referral (Diagnosis or History relevant to referral)

Physician Orders (Include: dose, route, rate/volume, frequency, and duration as applicable)

Attach list of Current Medications and Additional Orders (if required)

☐ ____

☐ ____

☐ ____

☐ ____

Tests Requested (check all that apply)

Community Paramedics will assess Vital Signs on arrival for all Patients (GCS, HR, RR, Temp, BP, SpO2)

☐ Blood Glucose ☐ Weight ☐ ECG (will be sent to referring physician office for review)

☐ Labs (Attach requisition) ☐ Other ____

Referral Source			
Clinic/Site Name	Clinic/Site Contact Name	Direct Phone	Fax

Physician Name	Direct Phone	Cell

Signature	Date