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 to the appropriate professional(s).

Date: _____	**Gender**: ❒Male ❒Female	Place sticker here (if used).
Surname: _____	**First:** _____	
Birth date: _____	**Personal Health Care Number:**_____	
Phone Number: _____	**Address:** _____	**Directions to home:** **Postal Code:** _____

Copy ❒Included or ❒Requested: ❒ MAR ❒ Allergy/Intolerance Record ❒ Laboratory 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/Things to Note

Pertinent Past Medical History

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

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

❒ New condition ❒ Chronic condition Describe: _____

Care Service Request:

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

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Request Details – frequency, time of day, etc.

(e.g.: TPR, BP 3x/week; BGM once weekly; BP q2d)

Comments:

Contact Health Care Team if:

Connecting With Clients/Patients/Residents & Families

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

Family member name/relationship: _____

Name of person who contacted family: _____ Date:_____

Connecting With Care Providers - **Denotes Required Field*

***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: _____ Employee Name (print): _____

Signature: _____

Consent for the *Collection, Use and Disclosure of Personal Health Information*

The Saskatchewan Health Authority (SHA) and Emergency Medical Services (EMS) are committed to respecting and ensuring that the privacy, security and confidentiality of personal health information collected, is consistent with *The Health Information Protection Act (HIPA)* of Saskatchewan.

The goal of the EMS Referral Program for Community Paramedicine is to support the overall health and wellness goals of clients/patients/residents to promote care close to home instead of institutional hospital setting.

SHA and EMS are seeking permission to collect, use and disclose personal health information to physicians, nurse practitioners, family members, community partners (home care, nursing, therapies) and/or services to provide assistance in the prevention of a future concerns or to assist with current healthcare needs.

Consent is completely voluntary - should you not consent to this referral request, the services and care we provide will continue, based on your care needs. Please consult your most responsible practitioner (physician or nurse practitioner) and local care team about the specific risks/benefits of not accepting a referral related to your care to ensure you are making an informed choice to accept or not accept additional treatment options. Without consent, healthcare information may not be shared with your healthcare team, and you may not have access to all of the healthcare service opportunities available in your area.

Questions regarding the collection, use or disclosure of personal health care information can be directed to your local health care team.

☐ **Yes,** I give EMS and SHA permission to collect, use and disclose my personal health information for the above noted purpose.

☐ **No,** I do not give EMS and SHA permission to collect, use or disclose my personal health information for the above noted purpose.

☐ **Written consent obtained (preferred)** ☐ **Verbal consent obtained**

_____	_____	_____
Patient Name (print)	**(Signature)**	**(Date)**
_____	_____	_____
Witness Name (print)	**(Signature)**	**(Date)**

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EMS & Community Paramedicine Fax Cover Sheet

To: EMS Service / SHA Department: Saskatoon Community Paramedicine	**Phone Number:** 306-975-8803 **Fax Number:** 306-975-8834
From: EMS Service / SHA Department:	**Phone Number:** **Fax Number:**
Number of pages (including fax cover):	
Date:	
Re: EMS Client Referral	

This client/patient/resident has consented to an EMS referral for an assessment or notification of a concern.

Please see the attached documents:

☐ EMS Referral & Consent

☐ Other:

We kindly request you respond to this fax to ensure this referral has reached the recommended healthcare professional.

Notice of confidentiality: This transmission is intended only for the recipients(s) listed above and may contain information that is time sensitive or confidential. If you are not the intended recipient, any use, disclosure, copying or communication of the contents of this transmission is prohibited. If you have received this fax in error, please notify the sender immediately and destroy this copy.
