COMMUNITY PARAMEDIC REFERRAL FORM

ARE THERE ANY SAFETY CONCERNS?
☐Yes ☐No

Last Name	**First Name**
Date of Birth (YYYY/MM/DD)	Gender ☐ Male ☐ Female
Physical Address	Mailing Address
Phone	Cell

Referral Information	Reason for Referral:		
	Diagnosis Relevant to Referral:		
Medical Information	Allergies: ☐Yes *(Please Attach List)*	☐No	☐No Known Allergies
	Medications *(Please Attach List)* :		
	Medical History *(Please Attach List):*		
Available Services	Physician or Designate Orders are required for these services. *(Orders must be attached)* : ☐ Wound Care (suture removal) ☐ Medication Administration ☐ Urinary Catheterization ☐ In-Home Blood Components & Products Transfusion	**Please Contact Community Paramedic at (352) 239-7696 if the service you are requesting is not listed.**	
Orders	Please document dose, route, rate/volume, frequency & duration:		
Available Procedures	Community Paramedic will assess GCS, HR, RR, BP, Temp, Sp02. ☐ 4/12/15 Lead ECG ☐ $ETCO_2$ ☐ Blood Glucose Level ☐ Weight	☐ Orthostatic Blood Pressure ☐ Blood Collection ☐ Urine Collection ☐ Microbiology Collection	
Treatment Schedule	For same day treatment, please contact the program at (352) 239-7696 for availability. Please list visit date(s):		
Physician/ Designate	Name	Signature	Date (YYYY-MM-DD)
	Phone/Pager *Indicate phone/page number for direct consultation (if necessary)*	Cell	
Referring Clinic	Name		
	Phone	Fax	

Completed form may be emailed to: MCFRCP@Marionfl.org
Please call (352) 239-7696 to confirm referral has been received.

Additional Notes/Comments: