EMS Community Paramedicine
Patient Referral

PATIENT INFORMATION — ⓘ REQUIRED

LAST NAME	FIRST	MI	GENDER Male Female

DOB	OHIOHEALTH MRN	HOSPITAL OF RECORD

ADDRESS	CITY	STATE	ZIP CODE

HOME PHONE	MOBILE PHONE	EMAIL

REFERRAL TYPE — ⓘ REQUIRED

☐ Adherence Concern	☐ Is Frequent Healthcare or EMS Utilizer
☐ Has Established Care Plan	☐ Is Hospital Readmission Risk
☐ Healthcare Provider Recommendation	☐ Needs Connections to Additional Services
☐ Has New or Complex Diagnosis	☐ Needs Post-Hospital Discharge Follow-Up
☐ Needs Clinical or Social / Home / Environmental Assessments	☐ No-Show at Heart Failure Clinic Appointment(s)

REFERRAL REASON

CLINICAL NEEDS
SOCIAL / HOME / ENVIRONMENTAL NEEDS
OTHER

PRIMARY CARE PHYSICIAN

PHYSICIAN NAME	GROUP / SERVICE / UNIT NAME

ADDRESS	CITY	STATE	ZIP CODE

DIRECT PHONE	FAX	EMAIL

SPECIALTY CARE PHYSICIAN

PHYSICIAN NAME	GROUP / SERVICE / UNIT NAME

ADDRESS	CITY	STATE	ZIP CODE

DIRECT PHONE	FAX	EMAIL

REFERRED BY — ⓘ REQUIRED

NAME	GROUP / SERVICE / UNIT NAME

ADDRESS	CITY	STATE	ZIP CODE

DIRECT PHONE	FAX	EMAIL

OhioHealth Emergency Medical Services Community Paramedicine
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