EMS Community Paramedicine

Patient Referral

OhioHealth

PATIENT INFORMATION

DATE	LAST NAME	FIRST	MI

GENDER IDENTITY	DOB	OHIOHEALTH MRN	HOSPITAL OF RECORD

ADDRESS	CITY	STATE	ZIP CODE

HOME PHONE	MOBILE PHONE	EMAIL

REFERRAL TYPE • CHECK ALL THAT APPLY

☐ Has Adherence and/or Compliance Concern	☐ Needs Post-Hospital Discharge Follow-Up
☐ Has Established Care Plan	☐ Needs Social, Home, and/or Environmental Assessment
☐ Has New Diagnosis	☐ Needs Wellness Check, Assessment or Care Management
☐ Has Complex Diagnosis	☐ Needs Connections to Additional Services or Resources
☐ Is Frequent EMS and/or Healthcare Utilizer	☐ No-Show at Recent Appointment(s)

SITUATION

DESCRIBE THE SITUATION.

BACKGROUND

DESCRIBE RECENT EVENTS, ENCOUNTERS, AND CONDITIONS

ASSESSMENT

I THINK THE PROBLEM IS… I AM NOT SURE WHAT THE PROBLEM IS BUT… I AM CONCERNED BECAUSE…

RECOMMENDATION

THEY MAY BENEFIT FROM… THEY NEED A CONNECTION TO… CAN YOU…

REFERRED BY

NAME	GROUP / SERVICE / UNIT NAME

DIRECT PHONE	FAX	EMAIL

OhioHealth Emergency Medical Services | Community Paramedicine

614-566-7632 office • 614-533-0234 fax • OhioHealthEMS.com/paramedics • paramedics@ohiohealth.com

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