EMS Community Paramedicine

Patient Referral

OhioHealth

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 • CHECK ALL THAT APPLY — ◀ REQUIRED

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

REFERRAL REASON — ◀ REQUIRED

DESCRIBE THE PATIENT SITUATION AND NEEDS; CONSIDER CLINICAL, SOCIAL, HOME, & ENVIRONMENTAL CONCERNS

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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