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	☐ New or Complex Diagnosis
☐ Clinical and Social Needs Assessments	☐ Post-Hospital Discharge Follow-Up
☐ Frequent Healthcare or EMS Utilizer	☐ Wellness Check
☐ Hospital Readmission Risk	☐ Other

REFERRAL REASON

CLINICAL NEEDS
SOCIAL 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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