COMMUNITY PARAMEDIC REFERRAL FORM

Brought to you by the Health Council of East Central FL

Last Name:	First Name:
Date of Birth: (MM/DD/YYYY)	
Gender: Male Female	
Physical Address:	Mailing Address:
Phone: ( ) -	
Preferred/ Primary Language:	

Section	Field	
Referral Information	Reason for Referral:	Objective:
	Diagnosis:	
Medical Information	Allergies: ○ Yes (Attach if available) ○ No Known Drug Allergies (NKDA)	
	Medications: (Attach List)	
	Medical History: (Attach List)	
Available Services	Physician or designate orders are required for these services (orders must be attached). Please select service(s). ○ Home Safety Check ○ Fall Assessment ○ Chronic Disease Management ○ Medication Compliance Monitoring ○ Vaccinations Wellness Checks Wound Care	Please contact Health Council of East Central Florida 407-710-8962 or Lhutcheson@hcecf.org *for referral assistance*
Orders	Please documents dose, route, rate/volume, frequency & duration:	
Treatment Schedule	For same day treatment, please contact at (407)710-8962 for availability. Please list visit date(s).	
Additional Healthcare Members	Home Health Agency:	Social Worker:
	Case Manager:	Other Healthcare Member:
Referring	Name:	
	Phone: ( ) -	Fax: ( ) -
Physician/ Designate	Name:	Phone: ( ) -
	Signature:	Date: (MM/DD/YYYY)

Please note that Community Paramedic will assess the following Vital Signs - HR, RR, B/P, Temperature and SPO2 during visit.