HCCSS HNHB Community Paramedicine Communication Form

Choose Home and Community Care Team

Community Paramedicine & Patient Information

Service Name_____ Visit Date_____ Paramedic's Name _____

Paramedic's OASIS Number _____ Patient Name _____

HCN _____ VC _____ DNR Confirmation Number _____

Living Status _____ Type of Housing _____

Patient S.O.A.P Note

SUBJECTIVE	
OBJECTIVE	
ASSESSMENT	
PLAN	

Does patient have 3 or more ambulatory care sensitive chronic health conditions?

Patient Outcomes/Referrals

Patient Disposition _____ Referrals _____

☐ Discharge Date _____ CP Faxed Communication form to the Primary Care Provider? ☐ Yes ☐ No

Reason

Visit Times

Request Received _____ Arrive Scene _____ Depart Scene _____ Visit Number _____

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