HCCSS HNHB Community Paramedicine High Intensity and Long-Term Care Communication Form

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 Reason Date ____________________________ CP Faxed Communication form to the Primary Care Provider? Yes No

Visit Times

Request Received _______________ Arrive Scene ______________ Depart Scene _______________ Visit Number ______________

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