Oxford County Paramedic Services
Remote Patient Monitoring Referral Form

Please fill out fields, sign and **fax to Oxford County Paramedic Service** at **519-421-7363**

Community Paramedicine led 90-days remote monitoring program to help moderate to severe chronic disease patients and frequent users of 911 calls self-manage their conditions through regular monitoring of vitals & health coaching.

Patient Demographics:

Legal Name (First, Last):	Preferred Name:	Sex: ☐M ☐F ☐Other Gender: ☐M ☐F ☐Other ☐Prefer not to answer
Address:	City:	Province:
Postal:	Home Phone:	Cell Phone:
Health Card #:	Version Code:	Date of Birth (MM/DD/YY):
Emergency Contact Name:	Relation:	Phone number:

Has the patient ever **received** Community Paramedicine **Remote Care Monitoring** or Home & Community Support Services **Tele-monitoring program** before?   ☐ Yes ☐ No ☐ Unsure

Will the patient be **using the program** with the support of a **caregiver**?   ☐ Yes ☐ No

Eligibility Screening (Select all that apply):

☐ Patient has agreed to be referred to program **AND**

☐ Patient has used 911/ED in past 12 months or is at risk of using 911 or visiting ED because of exacerbations related to the **following** chronic health conditions:

Chronic Disease (select all that apply)	Baseline (if available)	Target
☐ CHF (Congestive Heart Failure)	Weight:	Weight:
☐ COPD (Chronic Obstructive Pulmonary Disease)	SpO2:	SpO2:
☐ DM (Diabetes mellitus)	Range:	Range:
☐ HTN (Hypertension)	BP SYS / DIA:	BP SYS / DIA:

General Health Condition of the patient:

Mobility	☐ Full assist ☐ Partial Assist ☐ Independent ☐ Other, specify_____
Cognition	☐ No Cognitive Impairment ☐ Subjective Cognitive Impairment ☐ Mild Cognitive Impairment ☐ Dementia
Nutrition	☐ Well-nourished ☐ At risk for malnutrition ☐ Malnourished

Any additional information that *referrer* would like to attach with the referral (Select all that apply):

☐ Medication Records ☐ Lab reports ☐ DNR Orders ☐ Previous vital signs trends ☐ Other (Please specify below)

_____

Referrer Details:

Clinician Type:	Organization Name:	Phone:
Date Referral Made:	Address:	Fax:
Billing Number:	Professional ID:	Signature

If the patient is not connected to health care services/referral is not from a PCP, please **provide a contact number** for referring agency/provider in the event additional information or reporting back is required. _____

Please flip the page over and refer to Reading Alert Thresholds for Monitoring Equipment on Page 2

Community Paramedicine will use the **following default alert thresholds** when monitoring the patient. **If different** alert thresholds are recommended for your patient, please **indicate patient range in the chart** below. When triggered, these alert thresholds will generate a response from Community Paramedicine. In the event that **more than one chronic disease** is being monitored, alerts will be set to trigger at the lower or higher threshold accordingly.

READING ALERT THRESHOLDS FOR MONITORING EQUIPMENT

Alert Thresholds	Changes Required
CHF: • Weight gain of 1 kg in 24 hours, 2 kg in 48 hours or 3+ kg in 7 days • SpO2 < 92% • HR < 50bpm or > 110bpm • SBP < 90 mmHg or > 180 mmHg or DBP >110 mmHg	
DM: • BG < 4mmol/l or > 24 mmol/l • BG > 18 mmol/l over 3 consecutive days	
COPD: • SpO2 < 88% • HR < 50bpm of > 110bpm • SBP < 90mmHg or > 180 mmHG or DBP > 110mmHg	
HTN: • SpO2 < 92% • HR < 50 bpm or >110 bpm • SBP < 90 mmHg or > 140 mmHg or DBP > 110mmHg	