

**COMMUNITY PARAMEDICINE
REQUEST FOR PATIENT-SPECIFIC SERVICE**

NAME: _____
 PHN: _____
 DATE OF BIRTH: _____

DATE OF REQUEST (YYYY/MM/DD) STATUS NEW REQUEST RENEWAL COMMUNITY NAME

PATIENT INFORMATION

GENDER MALE FEMALE UNDEFINED
 PHYSICAL ADDRESS (Apt #, Street) CITY/TOWN, PROV POSTAL CODE
 PHONE # PRIMARY LANGUAGE ENGLISH FRENCH OTHER PLEASE SPECIFY: _____
 CO-HABITANTS SPOUSE PARENT(S) COMMUNITY CAREGIVER SIBLING(S) CHILD OTHER PLEASE SPECIFY: _____
 EMERGENCY CONTACT'S NAME RELATIONSHIP TO CLIENT BEST CONTACT PHONE #

REQUEST INFORMATION

REQUESTED START DATE (YYYY/MM/DD) PRIORITY URGENT NON-URGENT
 EXPECTED DURATION OF SERVICE ONE TIME VISIT ONCE A WEEK OVER 1 2 3 4 5 6 months
 *Please note that this request is valid for a maximum of six (6) months; a request will be required if services are to continue. TWICE A WEEK OVER 1 2 3 4 5 6 months
 OTHER PLEASE SPECIFY: _____
 PRIMARY DIAGNOSIS PATIENT GOAL (Character space is limited to visible area)
 HISTORY (Character space is limited to visible area) MEDICATION LIST ATTACHED
 SAFETY CHECK ATTACHED
 ADVANCED DIRECTIVE: YES (Please attach) NO RISKS IDENTIFIED:
 REQUEST INITIATED AT: Discharge Rounds Inter-Disciplinary/Home Health Team Emergency Department
 Physician/NP Office Walk In Clinic OTHER _____

SERVICES REQUESTED

<input checked="" type="checkbox"/> Initial assessment screen	<input type="checkbox"/> DIABETES	<input type="checkbox"/> PALLIATIVE SUPPORT
<input checked="" type="checkbox"/> Falls risk screen	<input type="checkbox"/> Capillary blood glucose	<input type="checkbox"/> Palliative assessment
<input checked="" type="checkbox"/> Patient home safety checklist	<input type="checkbox"/> Glucose meter use/maintenance	<input type="checkbox"/> Comfort care measures
<input checked="" type="checkbox"/> Head-to-toe assessment	<input type="checkbox"/> Review hypoglycemia	<input type="checkbox"/> Pain and symptom management review
<input checked="" type="checkbox"/> Vital signs (TPR, BP, SpO2)	<input type="checkbox"/> Foot assessment/foot care teaching	<input type="checkbox"/> Support discussions on advanced care plans, goals of care, MOST form
<input type="checkbox"/> COPD	<input type="checkbox"/> Home Health Monitoring (HHM)	<input type="checkbox"/> OTHER ASSESSMENTS
<input checked="" type="checkbox"/> Review flare-up action plan	<input type="checkbox"/> HEART FAILURE	<input type="checkbox"/>
<input type="checkbox"/> Inhaler device use/maintenance	<input checked="" type="checkbox"/> Review heart failure zones	<input type="checkbox"/>
<input type="checkbox"/> Peak flow meter use	<input type="checkbox"/> Blood pressure monitoring	<input type="checkbox"/>
<input type="checkbox"/> O2 equipment use/maintenance	<input type="checkbox"/> Weight check	<input type="checkbox"/>
<input type="checkbox"/> CPAP / BiPAP use/maintenance	<input type="checkbox"/> Home Health Monitoring (HHM)	<input type="checkbox"/>
<input type="checkbox"/> Home Health Monitoring (HHM)		<input type="checkbox"/>

PATIENT SPECIFIC DIRECTIONS/ORDERS: (Character space is limited to visible area)

REQUESTING PROFESSIONAL

PROVIDER NAME (Please print) SIGNATURE CONTACT NUMBER
 PROFESSIONAL: MD NP License Number: _____ RN OTHER _____ FAX NUMBER

RETURN COMPLETED FORMS TO THE COMMUNITY PARAMEDICINE OFFICE VIA FAX 1 250-953-3119
 For request processing or appointment booking inquiries, please contact: 1-855-353-5116 or email cp.coordinators@bcehs.ca

The BC Community Paramedicine Program accepts requests for service for patients living in the community with heart failure (HF), chronic obstructive pulmonary disease (COPD), diabetes; at increased risk for falls; and/or requiring palliative support. These patients require assessment or education in their home to support achieving their self-management goals, improving their health outcomes or support patients to remain in their home at end of life, and reducing emergency room visits as well as hospital stays.

Patient Eligibility Criteria:

- diagnosis of HF, COPD or diabetes; and/or
- requires an in-home assessment of falls risk; and/or
- requires palliative support.

Request Completion Guidelines:

- Requests for service will remain open for 6 months. If services are required beyond 6 months, a new request form must be submitted.
- Indicate on the request form the expected duration of service: one time visit (e.g. falls risk assessment) vs. multiple visits over weeks/months (e.g. COPD patient with frequent exacerbations requiring review of Flare-up Action Plan and inhaler device use).
- Indicate on the form what goal(s) you are trying to achieve through CP home visits.
- The following baseline assessments are carried out on all patients:
 - Initial assessment screen +/- the following:
 - pain assessment if patient has or has had any pain or soreness in the previous 2 weeks
 - medication self-management and generation of medication list if patient is on any medications
 - pressure ulcer risk assessment if patient is chair or bed-bound with impaired ability to reposition themselves.
 - mental health screens for depression, anxiety, and drug or alcohol dependence are completed after discussion with the health care team. These screens are not complete mental health assessments and are only done as an initial screen to determine the patient's mental status in order to determine if further evaluation by a trained professional is needed.
 - Vital signs (TPR, BP, SpO₂)
 - Head-to-toe physical assessment
 - Falls risk assessment and patient home safety screen
- Assessments done during subsequent visits are based on the patient's diagnosis and are guided by clinical practice guidelines specifically created to support CP practice.
- Additional assessments or education are to be selected as needed:
 - Diabetes: capillary blood glucose, glucose meter use review, hypoglycemia recognition and treatment, foot assessment/footcare teaching.
 - COPD: review Flare-up Action Plan, peak flow meter use, Inhaler device and maintenance review, O₂ equipment use and maintenance, CPAP/BiPAP use and maintenance
 - HF: review of heart failure zones, blood pressure monitoring, and weight check
 - Palliative: assessments [symptoms (ESAS-r, OPQRSTUV), performance scale (PPSv2), pain (PAINAD), confusion (CAM with PRISME), supportive and palliative indicators (SPCIT)], support pain and symptom management, support patients and care givers with discussions around disease progression, advanced care plans, wishes/goals of care and MOST form.
 - Requests for other assessments or education can be made and the CP, in collaboration with the Community Paramedicine leadership team, will determine if it is within scope of CP practice.
- Home Health Monitoring (HHM) can be arranged through CP services. Refer to HHM Eligibility Criteria to determine if your patient is eligible for home health monitoring.
- The CP will provide a report to the most responsible provider on a regular basis as determined by the team or immediately if further direction or alternative care is required.
- **Request form must be signed by the requesting professional (physician, nurse practitioner, registered nurse).**

Patient reports/updates from CP services delivered will be returned to this designated requesting professional.

MORE INFORMATION AVAILABLE AT: www.bcehs.ca/health-professionals