Yancey County
Community Paramedic Program

Referral Form

Fax completed form to (828) 641-9651 or send as an encrypted e-mail

Patient Information

Name: Date of Birth:

Address: Gender: ☐ M ☐ F

Insurance Card #: Phone:

Is the patient aware of the referral? ☐ Yes ☐ No Cell:

Referral Information ARE THERE ANY SAFETY CONCERNS FOR THE CP?: ☐ YES ☐ NO

Reason for Referral:

Diagnosis Relevant to Referral:

Clinical Information

Medical History: See Attached: ☐

Allergies:

Communicable Disease:

Referral Services

☐Fall Risk Assessment	☐Physical Assessment	☐Hypertension Follow Up
☐Home Safety Assessment	☐Vital Signs Assessment	☐Plan of care review
☐CO/Smoke Detector Assessment	☐Blood Glucose Assessment	☐Blood Draw/Urinalysis
☐Medication Compliance	☐12 Lead/ 15 Lead ECG	☐Education
☐72hr Opioid Misuse Follow Up	☐Other: ______________________	

Referring Physician/Designate/Paramedic

Name: Signature: Date:

E-mail: Cell:

Referring Clinic/Agency

Name:

Phone: Fax:

Additional notes/Comments:

Click or tap here to enter text.