



City of Virginia Beach

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DEPARTMENT OF EMERGENCY MEDICAL SERVICES
 PROACTIVE SERVICES DIVISION
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EMS@VBGOV.COM

EMS HEADQUARTERS
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 VIRGINIA BEACH, VIRGINIA 23452
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Community Paramedicine / Mobile Integrated Healthcare Request

Call for Service Date	Incident Number*	Referring Medic
Client Name	SSN	MRN
DOB	Age	Gender
Address		ZIP Code
Home Phone	Cell Phone	Email Address

Service Request(s):

- Fall Risk Assessment
- Home Safety Assessment
- CO Detector Install
- Smoke Detector Install
- 24H Opioid Follow Up

Premise/MED Note(s):

- Autistic
- Bariatrics
- Bed Bound
- Blind
- Deaf
- LVAD/Artificial Heart
- Response
- Responder Safety**
- Ventilator Dependent
- Other: Describe

Referrals: (Complete other side also)

- APS** Checking either of these boxes **DOES NOT** satisfy your mandated reporter responsibilities
- CPS**
- Behavioral (Mental) Health (ES)
- Case / Care Management
- Code Enforcement / Hoarding (HNP)
- Home Health
- Housing (HRC)
- Hospice
- Hospital Readmit (ICM)
- Primary Care Group
- Project Lifesaver (VBPD)
- Regulation and Enforcement (EMS)
- Substance Abuse Peer Support (Pathways)
- Senior Services (SSSEVA)
- Social Navigator (HS)
- Veteran Services (VA)
- Other: Describe

Expectations:

*NOTE: A complete EMR must be on file for every referral that sources from an EMS call for service

Emergency Contact Information

Relationship	Name	Phone Number
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medical Care Team

Title	Name	Phone Number	Organization
Primary Care Physician	_____	_____	_____
Case / Care Manager	_____	_____	_____
Home/Skilled Healthcare	_____	_____	_____
Pharmacy	_____	_____	_____
Specialist (list specialty)	_____	_____	_____
Specialist (list specialty)	_____	_____	_____

Behavioral Health Team

Title	Name	Phone Number	Organization
Psychiatrist/Psychologist	_____	_____	_____
Counselor	_____	_____	_____
Mentor / Peer Sponsor	_____	_____	_____
Therapist	_____	_____	_____
Other (list)	_____	_____	_____

Social Services Team

Title	Name	Phone Number	Organization
Social Worker	_____	_____	_____
Other (list)	_____	_____	_____

Legal Team

Title	Name / Relationship	Phone Number	Organization
Power of Attorney	_____	_____	_____
Other (list)	_____	_____	_____

Insurance

Title	Group # / Policy #	Phone Number	Organization
Insurer	_____ / _____	_____	_____
Insurer	_____ / _____	_____	_____
Insurer	_____ / _____	_____	_____

Chronic Health Condition Yes No
Advanced Directive Yes No
Veteran Yes No

Living Will Yes No
DDNR Yes No

Your service provider may consult with various service providers both within and outside the City to help provide the most effective health care possible to you. I understand and agree that during those consultations my health information may be shared.

Signature

Date

The completion of this form is required for CP / MIH referrals and services.

This form should be completed for every APS or CPS case reported along with the time of report and persons name taking the report.

Please indicate if you already made the referral to an agency

Please indicate if you wish to be contacted on the follow up for the referral

Please take the extra time to research the information on the back of the form for cases where a referral is requested.

Names of any other doctors or psychiatrists who are listed as prescribers on the patient's medication containers

Life-changing medical events (surgeries, etc) and date they occurred

Names and dosages of medications that cannot otherwise be documented in Elite

What appointments the patient has coming up

Who the appointment is with

Date & time of the appointment

Phone number, if available

Transportation details (name & phone # of service, confirmation #, etc)

During subsequent visits crews should be directed to import this data into the PPCR using the Repeat Patient feature.

Although we would like the collection of this information to be a "one-time" effort crews should be checking all this information at every contact for updates.

Notify an EMS supervisor if the crew will be on scene for longer than 30 minutes to gather this information and assessment.