CLINTON AREA AMBULANCE SERVICE AUTHORITY
COMMUNITY PARAMEDIC PROGRAM

1001 S Oakland St St Johns, MI 48879
Phone: 989.227.5713 Fax: 989-224-7870

Community Paramedic Patient Order Form

Patient Information (face sheet is acceptable)

Date of Order:	Requested Date of Service:		Primary Language:	
Client Name: Last	First	Middle	DOB:	Gender:
Physical Address	City		State	Zip Code
Mailing Address (if different)	City	Middle	State	Zip Code

Insurance (for research purposes only): No ☐ Yes ☐ If yes, company:_____

DIAGNOSIS

Diagnosis: _____

Reason for Visit: _____

PREVENTION ASSESSMENTS

- ☐ Nutrition Assessment
- ☐ Social Evaluation/Social Support
- ☐ Home Safety Inspection
- ☐ Other

LABORATORY SPECIMEN COLLECTION (please include lab testing order sheet)

☐ Blood Draw ☐ iStat Test (N/A) ☐ Stool ☐ Urine

Requested Labs/Blood tubes: _____

CLINICAL CARE

Cardiovascular
- ☐ Blood pressure check
- ☐ EKG 12 lead
- ☐ Peripheral IV

Follow up/Post Discharge
- ☐ Diabetic F/U, Education
- ☐ Neurological Assessment

Respiratory
- ☐ Asthma meds/ed/compliance
- ☐ CPAP
- ☐ MDI use
- ☐ Nebulizer usage/compliance
- ☐ Peak flow meter ed/usage
- ☐ Oxygen saturation check

General
- ☐ Assessment/H&P
- ☐ Ear exams
- ☐ Medication evauationl/compliance
- ☐ Post injury/illness evaluation
- ☐ Post stroke assessment, F/U
- ☐ Weight check

☐ Dressing change/wound check/type:_____

☐ Discharge follow up/diagnosis:_____

Other orders/information:_____

_____

_____

Ordering Physician Signature (Must be signed)

Contact Number:_____

Referring Physician:_____

(Please Print)

_____

Signature Date

Return report to:_____

Disclaimer; All visits will be accomplished as soon as possible but generally within 24-72 hours All services provided must be within the scope of practice of a Paramedic as defined by the State of Michigan. Paramedics will verify tht orders fall within this scope of practice and will contact you if orders need clarification or further instruction.