Greater Kennebec Community Paramedicine
Working together to improve community health

29 Chase Ave
Waterville, Maine 04901
Phone 207-861-4224
Fax 207-861-4474

Greater Kennebec Community Paramedic

Community Paramedic Patient Order Form

PATIENT INFORMATION		PLEASE SUBMIT BY FAX TO 207-861-4474
Date of Order:	Requested Date of service:	Primary Language:

Client Name: Last First Middle DOB: Gender: ☐M ☐ F

Physical Street Address City/Town State Zip code Phone #

Mailing Address(If Different) City/Town State Zip code Phone #

INSURANCE (For Research Purpose Only) ☐ Yes ☐ No If yes, Company:

DIAGNOSIS	PREVENTION ASSESSMENT
Diagnosis:_____	☐ Food Security Assessment
Reason for Visit:_____	☐ Fall Prevention
	☐ Home Safety Inspection

LABORATORY SPECIMEN COLLECTION ☐ PLEASE INCLUDE LAB TESTING ORDER SHEET

☐ Blood Draw ☐ Urine/ Fecal Collection ☐ Other:_____

Requested Labs/Blood Tubes:_____

VACCINATION ADMINISTRATION

☐ Intra Muscular ☐ SUB Cutaneous ☐ Oral

VACCINE:_____ ☐ Intra Nasal ☐ Other:_____

CLINICAL CARE	EDUCATION	GENERAL ASSESSMENT
POST CARE FOLLOW-UP	EDUCATION (see reverse for expectations)	ASSESSMENT
☐ EKG 12-LEAD	☐ Asthma Meds/Education	☐ Assessment/ H&P
☐ Post Injury/Illness	☐ COPD Education	☐ Weight Check
☐ Diabetes Follow-up	☐ Diabetes Education	☐ Blood Sugar
☐ CHF Follow-Up	☐ MDI/Peak Flow Meter	☐ Oxygen Saturation
☐ Other	(Define the education expectations)	☐ Medication Compliance/Reconciliation

☐ Dressing Change/ Wound Check/Type_____

OTHER ORDERS/ IMFORMATION:

_____

_____

_____

ORDERING PHYSICIAN SIGNATURE (MUST BE SIGNED)	DISCLAIMER:
Contact Number:_____	All Visits will be accomplished as soon as possible but generally within 24 hours. All services provided must be within the scope of practice of a paramedic/EMT as described in Maine EMS Protocols and Medical Directors Practice Board. Paramedics/EMTs will verify that all orders fall within this scope of practice and will contact the referring physician if orders need clarification or further instructions.
Referring Physician: _____ (Please Print)	
_____ Signature _____ Date	
☐ Fax Visit Report back to referring physician	
☐ Fax Visit report to_____	
☐ PLEASE INCLUDE COPY OF PMHx, Meds and ALLERGIES	