KFD Mobile Integrated Health
Community Health Paramedic
Referral Form
Patient Information

Name: _____DOB: _____/_____ / _____

Address: _____

Phone: (_____)_____-_____ Gender: ☐ M ☐ F ☐ Other-_____

Check any that apply: ☐ Alaska Native (Tribal Affiliation?) _____

☐ Veteran ☐ Houseless ☐ Emancipated Minor

Referred by: _____Phone:_____

Email: _____Fax:_____

Please note a short reason for referral:

Please return completed form to kfdmih@ketchikan.gov
Please call (907)228-2461 with any questions

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Intake Questionnaire

Are there problems in the home that would contribute to adverse outcomes?	Has the client called 911 or visited the ED in the last 30 days?	Are the client's medications disorganized?
☐ Yes	☐ Yes	☐ Yes

Primary Care

Does the Patient/Client have a primary Care Provider (i.e. MD, NP, PA)? ☐ Yes ☐ No

If yes, provide name: _____

Location of Practice: _____

Phone: (_____)_____-_____ Secure Fax Number:_____

Please note any services patient is **currently receiving**:

☐ In-Home Health Nursing	☐ Community Living (i.e Assisted Living/Nursing Facility)	☐ SNAP Benefits/Meals on Wheels
☐ Hospice Care	☐ KIC Social Services Support	☐ Veterans Affairs
☐ Wound care	☐ KIC Mental Health Services	☐ Home/Community Care, **Specify**:
☐ Behavioral Health Counseling	☐ Other. **Please list.**	

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Eligibility Criteria

☐ Individual admitted to hospital or visited the ED **at least** twice in the last 30 days	☐ Greater **than 3** contacts with Primary Care Provider or Specialist in the last 30 days	☐ Rapid deterioration of normal state and no in-home services available
☐ Lack of Community Supports **OR** Community Supports cannot visit within 10 days post discharge.	☐ Addiction Issue(s)(e.g. alcohol, smoking, drugs, gambling, other): ***Please list*:**	☐ Chronic Disease(s) (e.g. diabetes, CHF, COPD, cancer, other) **and inability to access Specialist**: ***Please list.***
☐ End of life / Palliative / Hospice		
☐ Isolation or lack of support system	☐ Mental Health Hx (e.g. depression, bipolar, PTSD, schizophrenia, other) ***Please list*:**	☐ Other: ***Please list***:
☐ Frail/fall risk		
☐ Failure to cope at home or caregiver burnout		

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Services Requested

☐ Wellness check (Note Frequency/Dates)_____		
☐ Environmental/Home Safety assessment	☐ COVID @ Home	☐ Vital signs
☐ Postural hypotension assessment	☐ Diabetic foot assessment	☐ Nutrition assessment
☐ Fall risk assessment	☐Chronic Disease assessment. ***Please list.***	☐ Images (i.e. wound, environment etc.): ***Please list.***
☐ Mental health assessment (cognitive exam & depression scale)		
☐ Remote Care Monitoring		
☐ Medication review/compliance	☐ Physical assessment: ***Please list specific assessments.***	☐ Other: ***Please list.***
☐ Palliative Performance Scale		
☐ Caregiver assessment		

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KFD M.I.H. Consent for Collection, Use, and Release of Patient Information

Referring Agency:_____

Client/Patient Name:_____

DOB:_____/_____/_____ Email:_____

Address:_____

Phone: (_____) _____-_____ May we leave a voicemail at this number? Yes / No

The Ketchikan Fire Department and Mobile Integrated Healthcare Program hold patient privacy in the highest regard of sanctity. You have the right to choose how and when your information is collected, shared, and used by any persons involved in your care. KFD and MIH will not share your protected information without your explicit, informed consent.

By signing this form, you agree to allow KFD/MIH to provide your demographics and/or health information to specific departments, external agencies, or healthcare providers that will be directly involved in the coordination, planning, and delivering of services/ Healthcare to you. Also, by signing this form, I am acknowledging that I have been given suffice time for questioning and am satisfied with information regarding my information privacy rights as outlined in HIPAA and KFD regulations.

I understand that if I do not request to share my information, or revoke the privilege of sharing, I am still eligible for care. Within that understanding, I acknowledge that there are situations where KFD/MIH or external agencies may not need my permission to share my information. Such examples of times could include situations where KFD/MIH is required by law to report to Office of Child Services or Adult protective services for suspected abuse, or in cases of potential serious harm to myself or others.

_____	_____	_____
Patient Signature	Printed Name	Date
_____	_____	_____
Patient Caretaker Signature (If Applicable)	Printed Name	Date
_____	_____	_____
Witness Signature	Printed Name	Date

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