Initial Intake Form
Community Paramedic Program

To be completed upon initial in-home patient meeting.

PATIENT INFORMATION

Name: _____ Mobile Phone #: _____

Address: _____

Date of Birth: _____ Social Security #: _____

Primary language: _____ Co-habitants: _____

Home Safety Precautions: _____

PATIENT MEDICAL HISTORY

Primary Care Physician: _____

Specialty Care Physicians: _____

Does the patient have a valid DNR: _____ DNR attached or location in home: _____

Do you have any substance abuse or alcohol use concerns?: _____

Diagnosed medical conditions: _____

_____

_____

Allergies: _____

_____

Medications: _____

_____

_____

Immediate Needs: _____

_____

Prevention Category: _____

I, _____, agree to become a patient of Bradford County Fire Rescue's Community Paramedicine program. I understand the goal of the program is to improve my health status and facilitate continuity of care with my health care providers.

Client signature: _____ Date: _____

CRP Provider: _____ Date: _____