Action Step 4

Mesa County Physicians IPA Care Coordination Agreement Referral Form

**Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Time:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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| **Provider Referral Request Form** | | | | | | | | |
| **Referring To** | **Specialty:** | **Phone:** | | **Fax:** | | | **Date:** | |
| **Practice Name & Address:** | | | | | | | |
| **Please Schedule (select all that apply):**  🞎 Urgent-- Referring physician called \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  🞎 Routine Appointment with Specific Physician listed:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  🞎 First Available with any Physician | | | | | | | |
|  | **Referring Provider’s Name:** | | | **Phone:** | | | | **Fax:** |
| **Type of**  **Referral** | 🞎 Medical Consultation with treatment recommendations that primary care physician will continue to follow  🞎 Procedural Consultation | | 🞎 Specialist to Specialist\*–Secondary Referral  \*Send copy of this referral to patient’s  Primary Care Physician. | | | | | |
| 🞎Co-management: Assume principal care for this condition | | 🞎 Other (designate)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |
| 🞎 Co-management: I prefer to share the care for this condition | |  | | | | | |
| **Patient Information** | Patient Full Legal Name: | | | | | DOB | | |
| If patient is under 18 years old – Parent Contact Name: | | | | | | | |
| Preferred Phone: | | | | Best time to call: | | | |
| Special Patient Considerations: | | | | | | | |
| Patient Insurance Information: | | | | | | | |
| Patient’s Primary Care Provider: | | | | Phone: | Fax: | | |
| **General**  **Information** | **Reason for Referral (*Clinical Question or Synopsis*):** | | | | | | | |
| **Comments/Considerations Related to Clinical Question:** \*\*Please include recent labs, pertinent imaging reports, medication list, problem list, allergies, and relevant clinical notes.\*\* | | | | | | | |
| **Patient aware of reason for referral?** 🞎 Yes 🞎 No: Explain | | | | | | | |

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| **Provider Referral Confirmation** | | |
| **Referral Confirmation** | **Referral Accepted?** 🞎 Yes 🞎 No: Explain | |
| **Appointment Scheduled with:** | **Date & Time of Visit:** |
| **Request for additional supporting clinical information (please detail):** | |
| 🞎Patient prefers to contact specialist to schedule at a later date | |
| 🞎 Patient declined appointment; Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Reason:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| 🞎Patient cancelled appointment on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and rescheduled for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| 🞎Patient cancelled appointment on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and did not wish to reschedule. | |
| 🞎Patient was NO SHOW for appointment on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. | |
| **Person completing confirmation:** | **Date of Confirmation:** |