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:** |