



Physicians CareConnection Referral Form

Today's Date _____

Name of Patient _____
(Last) (First) (Initial)

Street Address _____ Telephone (home) _____

City _____ State _____ Zip _____ Telephone (alternate) _____

Date of Birth: _____ Residency Status: US Citizen Permanent Resident Non-Immigrant Visa Student

Insurance Status: None Medicaid Medicare Private Insurance VA Benefits Gender: Male Female

Referred from _____
(Private Practice, Clinic, Hospital, Social Service Agency)

Is this patient enrolled in the Voluntary Care Network? ____ Yes ____ No

Does this patient require an interpreter? ____ Yes ____ No If yes, what language? _____

If this patient requires an interpreter, please list the contact information of someone who speaks English so that we are able to make initial contact with this patient to coordinate their care.

Name _____ Telephone Number _____

REFER TO SPECIALTY (UNINSURED PATIENTS ONLY, PLEASE MARK ALL THAT APPLY BELOW)

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Allergy | <input type="checkbox"/> Infectious Disease | <input type="checkbox"/> Otolaryngology | <input type="checkbox"/> Surgery-Cardio-Thoracic |
| <input type="checkbox"/> Cardiology | <input type="checkbox"/> Nephrology | <input type="checkbox"/> Primary Care | <input type="checkbox"/> Surgery-General |
| <input type="checkbox"/> Dermatology | <input type="checkbox"/> Neurology | <input type="checkbox"/> Pulmonary | <input type="checkbox"/> Surgery-Colon/Rectal |
| <input type="checkbox"/> Dental | <input type="checkbox"/> Neurosurgery | <input type="checkbox"/> Physical Medicine | <input type="checkbox"/> Surgery-Ortho |
| <input type="checkbox"/> Endocrinology | <input type="checkbox"/> Ophthalmology | <input type="checkbox"/> Physical Therapy | <input type="checkbox"/> Surgery-Vascular |
| <input type="checkbox"/> Gastroenterology | <input type="checkbox"/> Optometry | <input type="checkbox"/> Podiatry | <input type="checkbox"/> Urology |
| <input type="checkbox"/> GYN | <input type="checkbox"/> Orthopedic | <input type="checkbox"/> Rheumatology | |

PLEASE ATTACH THE FOLLOWING: Problem List, Medication List, Recent Labs, and/or Diagnostic test reports appropriate for this referral.

Reason for Referral:

Physician Signature/Date

REFER TO PATHWAYS NAVIGATION PROGRAM (MEDICAID PATIENTS ONLY, PLEASE MARK ALL THAT APPLY)

- Diabetes (United HealthCare Community Plan ONLY)
 Pregnancy (Buckeye, CareSource, Paramount, United HealthCare Community Plan ONLY)

Staff Scheduling Referral (please print)

Phone Number