

Care Coordination Request Form

PATIENT BACKGROUND:

Patient Name	Patient HIC#
Patient Address	Physician Name
Patient Phone	Physician Phone
Patient Birth Date	Emergency Contact/Caregiver Information

DIAGNOSIS:

Diabetes COPD CHF CAD

Other _____

Special Instructions _____

Date of Last Physician Appointment ___/___/___

Next Physician Appointment ___/___/___

REASON FOR REQUEST: INPATIENT

Admitted to Hospital

Admission Date ___/___/___

Hospital Name _____

Hospital Phone (____) ____ - ____

Admitted to LTAC/SNF/LTC

Admission Date ___/___/___

Facility Name _____

Facility Phone (____) ____ - ____

Inpatient Discharge Follow Up

Discharge Date _____

Discharge Diagnosis _____

Frequent ER Admission

Frequent OBS/Inpatient Stay

REASON FOR REQUEST: OUTPATIENT

Outpatient Procedure/ Services Follow Up

Additional Health Education Needed

Identified at Risk

Non-Adherence

Other _____

REASON FOR REQUEST: MISCELLANEOUS & SOCIAL NEEDS

Care Coordination with Specialist

Specialist Type _____

Specialist Name _____

Specialist Phone (____) ____ - ____

Community Resources

Social/Family Support Assessment

Comments: _____

Referring Staff member _____

Staff Member's Preferred Method of Contact and
Contact info: _____

CONFIDENTIAL: This facsimile message and its contents are or may be legally privileged and confidential information intended solely for the recipient. You are hereby notified that any dissemination, distribution, copy or other use of this message or its contents is strictly prohibited. If you have received this facsimile in error, please notify us immediately by telephone at 1-877-486-2048 and return the original message to us at 4888 Loop Central Drive, Suite 700, Houston, TX 77081 via the United States Postal Service and destroy all electronic and hard copies of this communication, including any attachments.

FAX TO: 1-877-275-1106