

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: _____

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