Accountable Care Coalition of Southeast Wisconsin
Established by Independent Physicians Network, Inc.

Date: ___/___/_____

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: _____

_____

FAX TO: 1-855-793-6305