**Community Health Program – REFERRAL FORM**

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| --- | --- | --- | --- | --- | --- |
| Referring Person: Person making referral | | | | Referral Date: Referral date | |
| Referring Agency: Referring agency | | Phone Number: Phone number | | | |
| Fax Number: Fax number | | Email: Email | | | |
| Affiliation to Patient | Caseworker | | Social Worker | | Physician |
| Program Type | Obs Avoidance (7 day) | | CHF (30 day) | | HUG (90 day) |
| Admission/Readmission Avoidance (30 day) | | Hospice | | Home Health |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Patient Name: Patient name | | | Date of Birth: D.O.B. | | | | Gender: Male | |
| Patient’s Address & Apt or Lot Number: Patient address | | | | | | | | |
| City: City | | State: TX | | | | Zip: Zip code | | |
| Phone: Patient phone number | | | | Alternate Phone: Patient alternate phone number | | | | |
| Primary Medical Condition: Primary medical Condition | | | | | Expected Discharge Date: D/C Date | | | |
| Physician 1: | Type: | | | Phone #: | | | | Fax #: |
| Physician Name | Physician Type | | | Phone | | | |  |
| Physician 2: | Type: | | | Phone #: | | | | Fax #: |
|  |  | | |  | | | |  |
|  |  | | |  | | | |  |

**Please include most recent (if available):**

|  |  |  |  |
| --- | --- | --- | --- |
| Face-sheet | History & Physical | Home Medication List | |
| Discharge Instructions | 12 Month visit history, with date, diagnosis and admit status | | |
| Number of ED visits in last twelve (12) months that ***did not*** result in inpatient status: | | |  |
| Number of inpatient admissions in last twelve (12) months: | | |  |

These documents help up establish patient demographics, the names of the patient’s physicians, a comprehensive medical history, what medications the patient’s physicians expect them to take regularly and what the patient is expected to do after discharge.

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| Special Considerations / Additional Information |
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Please fax: **(817) 632-0530**

Or email to: [**chpreferral@medstar911.org**](mailto:chpreferral@medstar911.org)