**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 | [x]  Obs Avoidance (7 day) | [x]  CHF (30 day) | [x]  HUG (90 day) |
| [ ]  Admission/Readmission Avoidance (30 day) | [ ]  Hospice | [ ]  Home Health |

|  |  |  |
| --- | --- | --- |
| 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**