

# 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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