

**Care Coordination Referral Form Send to:** [**CareCoordRefer@dvaco.org**](mailto:CareCoordRefer@dvaco.org)

**Phone: (610) 225-6277 Or Fax: (484) 476-9003**

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| Patient Information |
| Last Name: First: Middle Initial:  Date of Birth: Sex: M F City: State:  Date of Patient’s Next Appt: Primary Care Provider: Contact information for Patient or Care Giver: |
| *Reason for Referral* |
| 2 or more inpatient admissions within the last year Chronic pain, exhausted resources  Hospital readmission within 30 days of DC Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  2 or more ED visits within the last 6 months  Significant impairment in 2 or more ADL’s  Inadequate support system  Behavioral health condition  Active substance abuse or dependence  Medication adherence issues |
| *Interventions Already Tried:* |
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| *Goals:* |
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| *Follow-Up Information* |
| Important:  Please attach the following items to this referral form   1. Current Medication List 2. Most recent physician clinic note and/or hospital discharge summary 3. Most recent laboratory data- including disease specific markers, such as HgbA1C, lipid profile, ejection fraction, etc.   Name of Person Making Referral: Contact Phone  Email: |
| To be Completed by DVACO  Care Coordinator Assigned Phone:  Date of Review Contact email |

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