

**Care Coordination Referral Form Send to:** **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:* |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| *Goals:* |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| *Follow-Up Information* |
| Important:Please attach the following items to this referral form1. 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 DVACOCare Coordinator Assigned Phone: Date of Review Contact email  |

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