

FORM REFERRAL FORM FOR EXAMINATION OR TREATMENT

Purpose of Form

This form provides continuity of clinical care and provides adequate information to physician and/or medical facilities so all consumers will have written documentation and information about current problems and current medication and treatments accompanying them. The person accompanying the consumer to the medical visit makes sure referral form is complete with written information in the sections below. If additional paperwork is required it should accompany this form.

Instructions for Preparation of Form

The following sections are completed by provider Health Care Coordinator (H.C.C.) for individual:

- Consumers name, DOB, case number and appointment date and time, consumer's current address and phone number.
 - The provider who cares for the consumer. This may be an agency or an independent person.
- The case manager of the consumer.
- Referred to: Place the name of the physician or the medical facility the consumer is going to. If unknown (if taken by ambulance place "in route by Ambulance.")
- Consumer's Legal Guardian will be identified to provide the physician with appropriate contact when required.

CURRENT MEDICATIONS/TREATMENTS. Name of medication, dosage, amount of the medicine, times it is usually administered. It is okay to place information right off of the medical sheet or label from medication bottle. Main component is to provide receiving health provider with up-to-date information regarding all medication the consumer is on so they are aware of potential drug interactions with other medications that they may be considering prescribing. **IT IS IMPORTANT TO PLACE ANY OVER THE COUNTER OR PRN MEDICATIONS IN THIS SECTION ALSO SO THE HEALTH PROVIDER WILL KNOW ANY POSSIBLE MEDICATION THE CONSUMER IS ON.**

Any allergies relating to medication, food or the environment should be placed in the allergy section. Most of these allergies may be found in the consumer's home record.

REASON FOR VISIT. Person filling out form (usually the Health Care Coordinator), provides written documentation providing the receiving health provider with information describing the current reason the individual is being seen. This information needs to be specific enough so the physician may be able to read and provide accurate assessment of the consumer's concern. Person completing the form signs name, title and date.

PHYSICIAN/MEDICAL FACILITY SECTION:

Diagnosis/Findings: What the physician is actually able to access by a physical examination of the consumer. This conclusion is sometimes obtained from information which the physician receives from consumer and/or the provider with the consumer.

Recommendations: What the physician recommends based on the diagnosis or findings. This may include some general non-prescriptive information which the physician feels appropriate to provide care to the consumer from the findings. At times the recommendations will be none.

Treatments: What course of treatment the physician chooses to take to provide adequate medical intervention. Includes prescriptions and physician orders.

Physician signs name and date of service.

Routing of Form

Original to physician, one copy for home record, one copy sent to case manager within one working day of referral appointment.

REFERRAL FORM FOR EXAMINATION OR TREATMENT

Name:		DOB:
Case No:	Appointment Date/Time	
Address:		
Phone:		
Provider:		
Case Manager:		
Referred To:		
Legal Guardian:		

A

CURRENT MEDICATIONS/TREATMENTS

Name of medication, dosage amount; times administered, include any over-the-counter and/or P.R.N.

M

ALLERGIES. Include medication/food environmental allergies: _____

REASON FOR VISIT:

P

Signature and Title of Person Completing Form

Date

PHYSICIAN/MEDICAL FACILITY SECTION

Diagnosis/Findings:

L

Recommendations:

Treatments:

E

Physician Signature

Date

Routing: Original to physician, one copy for home record, one copy sent to case manager, within one working day.