

**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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