SHORE QUALITY PARTNERS

CARE COORDINATION REFERRAL FORM

Please complete this form and fax it to (609) 653-1893

If you have any questions please call Luz Valentin at (609) 365-6265

Name: _____ Date of Birth: _____ Gender: M F

Address: _____

Email: _____ Home Phone: _____

Cell Phone: _____ Work Phone: _____

Referring Physician: _____ Primary Care Physician: _____

Insurance: _____ Group: _____

ID Number: _____ Ins Phone #_____

Diagnosis:

- ☐ Diabetes
- ☐ COPD
- ☐ Sleep Apnea
- ☐ Cardiovascular Disease
- ☐ Asthma
- ☐ Other _____

Additional history:

- ☐ Smoking history (current or history of)
- ☐ Etoh history (current or hx of)
- ☐ Drug abuse (elicit or rx)
- ☐ More than 2 ER Visits in the last 6 months
- ☐ More than 2 Hospitalization in a year

Special Needs:

- ☐ Mental health issues
- ☐ Cognitive Impairment
- ☐ Language Limitations
- ☐ Hearing
- ☐ Physical
- ☐ Vision
- ☐ Other _____

Consults: please attach prescription order

- ☐ Podiatry
- ☐ Endocrinology
- ☐ Diabetes Education
- ☐ Ophthalmology
- ☐ Pharmacy
- ☐ Social Work
- ☐ Sleep Study (Please attach sleep study referral form)
- ☐ Other _____

Pertinent Studies: please attach

- ☐ Medical history
- ☐ Most recent blood work results
- ☐ Medication list

Explanation of Referral

_____

What strategies or approach did you use in the past?

_____

By signing this form I hereby confirm that the above mentioned patient consents to the exchange of information between this practice and Shore Quality Partners to coordinate the continuation of care with other providers.

_____	_____	_____
Referring Provider Name (print)	**Referring Provider Signature**	**Date**

I hereby request Shore Quality Partners to coordinate the continuation of my care as stated above - to advise me of available providers and contact the provider(s) of my choice.

_____	_____	_____
Patient name (print)	**Patient Signature**	**Date**