Physicians CareConnection
An affiliate of the Columbus Medical Association

Physicians CareConnection Referral Form

Today's Date _____

Name of Patient _____
(Last) (First) (Initial)

Street Address _____ **Telephone (home)** _____

City _____ **State** _____ **Zip** _____ **Telephone (alternate)** _____

Date of Birth _____ **Residency Status:** □US Citizen □Permanent Resident □Non-Immigrant Visa □Student

Insurance Status: □None □Medicaid □Medicare □ Private Insurance □VA Benefits **Gender:** □Male □Female

Referred from _____
(Private Practice, Clinic, Hospital, Social Service Agency)

Is this patient enrolled in the Voluntary Care Network? ____Yes ____No

Does this patient require an interpreter? ____Yes ____No **If yes, what language?** _____

If this patient requires an interpreter, please list the contact information of someone who speaks English so that we are able to make initial contact with the patient to coordinate their care.

Name _____ **Telephone Number** _____

REFER TO SPECIALTY (UNINSURED PATIENTS ONLY), PLEASE MARK ALL THAT APPLY BELOW

__ Allergy	__ Neurology	__ Physical Therapy
__ Cardiology	__ Nutrition	__ Podiatry
__ Dermatology	__ Ophthalmology	__ Pulmonary
__ Dental	__ Optometry	__ Urology
__ Gastroenterology	__ Primary Care	__ Mental Health (PMHNP)
__ GYN	__ Physical Medicine	

PLEASE ATTACH THE FOLLOWING
Problem List, Medication List, Recent Labs, and/or Diagnostic test reports appropriate for this referral.

Reason for Referral:

_____

_____

_____
Physician Signature/Date

_____
Staff Scheduling Referral (please print) **Phone Number**

REFER TO PATHWAYS NAVIGATION PROGRAM (MEDICAID PATIENTS ONLY), PLEASE MARK ALL THAT APPLY

__Diabetes (United HealthCare Community Plan ONLY)
__Pregnancy (Buckeye, CareSource, Paramount, United HealthCare Community Plan ONLY)

_____
Staff Scheduling Referral (please print) **Phone Number**

Please fax COMPLETED REFERRAL to the PCC office at (614) 884-0123