Patient Referral Form

Primary care clinics may refer patients for **non-emergency, outpatient & elective** procedures. Wait time and travel depend on availability of surgeon/specialist volunteers.

In order to qualify, a patient must:

- ❖ Live in northern California
- ❖ Be uninsured and not covered by Medi-Cal, Medicare, or Workers Comp
- ❖ Earn up to 400% of the Federal Poverty Level: $5,020 per month for an individual, $10,400 for a family of four
- ❖ Not require ongoing care by an Operation Access specialist volunteer for successful recovery. (Referring clinic maintains responsibility for care after procedure and final appointment.)

First Name: ______________________________

Last Name: ______________________________

Address: ______________________________ Apt #:______

City/State/Zip: ______________________________

Cell phone #: ______________________________

Home/Other phone #:______________________________

Secondary Contact & Relation: ______________________

Secondary Contact phone #: ______________________

Preferred Language: ______________________________

English Speaker in household? ☐ Yes ☐ No

DOB: ______/______/_____ Sex Assigned at Birth: ☐ M ☐ F ☐ I

Gender Identity: ________________ Pronouns: ________________

☐ Check if unhoused and provide case manager contact information above.

Check if enrolled in ☐ CMSP full-scope or ☐ CMSP Connect to Care/Path to Health

Referral Date: ______________________________

Referring Clinic: ______________________________

Referring Provider: ______________________________

Phone: ______________________________ ext: __________

E-mail: ______________________________

If seen by specialist - Name: ______________________________

☐ Check if surgeon/specialist agrees to perform procedure.

Clinic Contact/Care Coordinator: ______________________________

Phone: ______________________________ ext: __________

Fax: ______________________________

Email: ______________________________

Please fill out <u>completely and fax</u>

Attach relevant clinical information, according to referral guidelines (check what is included):

- ☐ Relevant Progress Notes
- ☐ Most Recent H&P/Medical History
- ☐ Imaging Results
- ☐ Labs – Include Metabolic Panel
- ☐ Pathology Report
- ☐ Operative Reports
- ☐ Other ______________________________

Specify Procedure(s) Requested: ______________________________

____

Side (if applicable): ☐ Left ☐ Right ☐ Bilateral

☐ Requesting biopsy from Operation Access

If malignancy is detected, patient's medical home is responsible for coordinating follow-up care. Our scope of service is limited to the diagnostic procedure (with the exception of some in situ cancers).

Diagnosis/Symptoms/Relevant Treatment or Hospitalizations:

____

____

Body Mass Index (BMI): _________ Height: _______ Weight: _______

Visual Acuity (for eye referrals): OD_______ OS_______ OU_______

☐ Blind/Low Vision ☐ Deaf/Hard of Hearing ☐ Nonverbal

☐ Developmental Disability: ______________________________

☐ Mental Illness/Disorder: ______________________________

Current Medications: ______________________________

____

☐ History of cardiac issues: ______________________________

☐ Anticoagulants: ______________________________

☐ Allergies: ______________________________

____

Diabetes: ☐ Type 1 ☐ Type 2 – Controlled: ☐ Yes ☐ No

Comorbidities (check all existing or past conditions):

☐ Heart Disease ☐ Stroke ☐ Hypertension ☐ Lung Disease

☐ Kidney Disease ☐ Cancer ☐ Family Hx Cancer ☐ HIV/AIDS

☐ Substance Abuse ☐ Hx Substance Abuse ☐ Smoking ☐ Epilepsy

Other/Additional Info: ______________________________

f: 415.733.0019 | p: 415.733.0052 | referrals@operationaccess.org | operationaccess.org