Patient Referral Form for Alameda County

Fax: 415.733.0019 Ph: 415.733.0080
1119 Market St, Suite 400, San Francisco, CA 94103
Email: info@operationaccess.org Web: www.operationaccess.org

Operation Access office use:

First:____________________ Last:_________________________

Address:____

City/State/Zip:____

☐ Check if Homeless and provide Case Manager info

Best phone #:(__________)________________________________

Other phone #:(__________)_______________________________

Emergency Contact: ______________________________________

Contact phone #: (_______)_______________________________

Language:___________________ Ethnicity: _______________

English Speaker in household? ☐ Yes ☐ No

Date of birth: _____/_____/_____ Sex: M F

Clinic Contact Info

Referring Clinic: _________________________________

Referring Provider: _______________________________

If seen by specialist - Name of MD: ________________

Ph:(______)_______________ E-mail:__________________

Clinic Contact/Case Manager:_________________________

Ph:(______)_______________ E-mail:__________________

Fax:(______)_____________ Referral Date: ____________

Eligibility Guidelines

Patients may be referred for ***non-emergency, outpatient*** & ***elective procedures.*** *Available services depend on availability of volunteer doctors.*

In order to qualify, a patient must:

- ❖ Not have health insurance or Worker's Comp. coverage.
- ❖ Be currently ineligible for any publicly sponsored insurance including Medi-Cal, Health PAC or Medicare.
- ❖ Earn less than 250% of the Federal Poverty Level: $29,700 for individual, $60,750 for family of four.
- ❖ Not require ongoing care by specialist for successful recovery (referring clinic maintains responsibility for care after procedure and final appointment).

Last Updated: 2/11/2016

Please fill out completely and fax

Attach Relevant Clinical Information (check off what is included):

- ☐ Progress Notes (if relevant)
- ☐ Most Recent H&P/Medical History
- ☐ Imaging Results
- ☐ Labs
- ☐ Pathology Report
- ☐ Surgical Reports
- ☐ Other ______________________________

Procedure(s) Requested: ___________________________

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Check if a biopsy is being requested: ☐

If a malignancy is detected: the patient will be referred back to you (the medical home) for coordination of follow-up care.
OA's scope of service is limited to the diagnostic procedure.

Diagnosis / Symptoms / Relevant Treatment or Hospitalizations:

____

____

____

Visual Acuity (for eye referrals): __________________

Body Mass Index:___________________________________

Mental Illness?____________________Treated? ☐ Yes ☐ No

Current Medications:_______________________________

____

Anticoagulants?: ☐ Yes ☐ No

Allergies:____

____

Diabetes:_________________If yes: Controlled? ☐ Yes ☐ No

Co-Morbidities (circle all existing or past conditions):

Heart Disease Stroke Hypertension Lung Disease
Kidney Disease Diabetes Cancer Family History of Cancer
Active Substance Abuse History of Substance Abuse
Other ____