Operation Access

Patient Referral Form for Contra Costa County

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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, the Basic Health Care Program of Contra Costa Health Plan, 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: _____

_____

_____

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 _____