Patient Referral Form for Napa County

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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

OA is accepting a limited number of diagnostic colonoscopy referrals for patients who can travel up to 60 miles by car for their procedure. *Availability of other services must be determined prior to referral. Available services depend on availability of volunteer doctors.*

In order to qualify, a patient must:

- Not have health insurance or Worker's Comp. coverage.
- Not have a valid social security number.
- 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: 5/23/2016

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

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 / Hospitalizations:

____

____

____

GI referrals (must select one): ☐ FIT or FOBT+
☐ other diagnostic reason (list under diagnosis above)

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 ______________________________________