



### Patient Referral Form for San Mateo 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, ACE Program 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: 5/24/2016

#### 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 \_\_\_\_\_