Patient Referral Form for Solano 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

OA is accepting a limited number of referrals for patients who may have to travel up to 60 miles by car for their procedure.

Once provider participation is secured from facilities in Solano County, a larger number of referrals can be accepted.

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: 5/24/2016

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: ______________________________

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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:

____

____

____

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 ____