



# REFERRAL REQUEST FORM

PLEASE PRINT

Appointment Date: _____
Appointment Time: _____
Translation Required:    Y <input type="checkbox"/> N <input type="checkbox"/>
Language: _____

## Part A: Physician Requesting Referral

Physician: \_\_\_\_\_ Specialty \_\_\_\_\_

Charitable Clinic Name, if applicable \_\_\_\_\_ Contact Person \_\_\_\_\_

Address: \_\_\_\_\_ Email: \_\_\_\_\_

Phone: \_\_\_\_/\_\_\_\_/\_\_\_\_ Fax \_\_\_\_/\_\_\_\_/\_\_\_\_

## Part B: Patient Demographics

Patient Name: \_\_\_\_\_ M  F

Project Access ID # \_\_\_\_\_ Age \_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Phone # (home) \_\_\_\_/\_\_\_\_/\_\_\_\_ (work) \_\_\_\_/\_\_\_\_/\_\_\_\_

Address: \_\_\_\_\_ Apt # \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

## Part C: Diagnostic Procedure Requested

Level of Urgency: \_\_\_\_\_ STAT (immediate attention)    \_\_\_\_\_ ASAP (priority attention)    \_\_\_\_\_ 2-4 weeks

Diagnosis: 1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_

ICD 9: 1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_

Please provide most recent information that applies to this visit (check all that apply):  
\_\_\_ Labs    \_\_\_ Diagnostic Tests  
\_\_\_ Recent History

Diagnostic Procedure/Exam Requested

1. \_\_\_\_\_ 2. \_\_\_\_\_  
3. \_\_\_\_\_ 4. \_\_\_\_\_

## Part D: Specialist Requested

Level of Urgency:    \_\_\_\_\_ Acute (need within 30 days)    \_\_\_\_\_ Sub-acute (need within 31-90 days)  
\_\_\_\_\_ Chronic (need > 90 days)

Specialist Requested:

1. \_\_\_\_\_ 2. \_\_\_\_\_  
3. \_\_\_\_\_ 4. \_\_\_\_\_

What would you like the consulting physician(s) to answer?

1. \_\_\_\_\_  
2. \_\_\_\_\_

Please note that Project Access Dallas patients can be referred to only those physicians who participate in Project Access Dallas.

Physician Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_





## New Patient Enrollment Request Form

Patient Name \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_\_ Sex M  F

Home Phone # \_\_\_\_\_ Work Phone # \_\_\_\_\_

Street Address \_\_\_\_\_ Apt # \_\_\_\_\_ City \_\_\_\_\_ ZIP \_\_\_\_\_

Level of Urgency: \_\_\_\_\_ STAT \_\_\_\_\_ ASAP \_\_\_\_\_ 2-4 weeks \_\_\_\_\_ when possible \_\_\_\_\_ other

### **Physician requesting patient referral:**

Print Name (*Physician must be a participating PAD volunteer*) \_\_\_\_\_ Specialty \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ ZIP \_\_\_\_\_

Contact Person \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_

### **Hospital requesting patient referral:**

Hospital Name (*Hospital must be a participating PAD partner*) \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ ZIP \_\_\_\_\_

Contact Person \_\_\_\_\_ Department \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_

### **Diagnosis (please PRINT):**

\_\_\_\_\_  
\_\_\_\_\_

### **Reason for Referral (please PRINT):**

\_\_\_\_\_  
\_\_\_\_\_

Once PAD receives this form and the patient has been screened for eligibility, you will be notified. The enrollment process can take four to six weeks. If you are the patient's PCP, the patient will remain in your medical practice, where you will continue to serve as the patient's medical home.

Fax this form to the Dallas County Medical Society at 214-941-3351.

Questions? Call the Dallas County Medical Society at 214-413-1435.





## Medication Override Request Form

Prescribing Physician (please PRINT)

Physician \_\_\_\_\_ Specialty \_\_\_\_\_

Contact Person \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_

Patient Name \_\_\_\_\_ M  F

Project Access ID # \_\_\_\_\_ Date of Birth \_\_\_\_\_

What is the name and dosage of the brand medication(s) you are requesting and why is it being prescribed?

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

What is the name and dosage of the generic medication already tried for the above medication(s)?

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Complete the above information and sign and date. Fax completed forms to Project Access Dallas at 214-941-3351. This fax machine is located in a secure location as required by HIPAA regulations. Your brand request will be reviewed by the PAD medical director. We will return this form to you with the medical director's response written below. Questions? Contact Kambria Kennedy, Director of Patient Access and Utilization, at 214-413-1433 or [Kambria@dallas-cms.org](mailto:Kambria@dallas-cms.org). Thanks!

Medical Director Review:

- Approved  
 Not Approved

Due to the limited pharmacy benefit (\$1500 per year), we suggest the use of an alternative medication(s):

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_





## PATIENT DONATION FORM

Dear Project Access Dallas Patient:

Thank you for allowing us to serve you through Project Access Dallas. The physicians, clinics, pharmacists, hospitals, and many others volunteer their services to help you get well and stay well. Since we operate completely by donations, we ask you to donate \$5 to help cover the costs of managing this project.

Thank you in advance for sending your donation in the attached envelope.

Patient Name:

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Patient ID Number:

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Physician:

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Date:

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Address envelope to:

**DCMS Foundation**

**P.O. Box 4680**

**Dallas, TX 75208**

If you have questions, call Rosie Munoz at 214-413-1425.

Thank you for letting us serve you!





## FORMA DE DONACION DEL PACIENTE

Estimado paciente de *Project Access Dallas*:

Gracias por permitirnos servirle a través de *Project Access Dallas*. Los doctores, las clínicas del área, los farmacéuticos, los hospitales, y muchos otros voluntarios están donando sus servicios para asistirle a mejorar y a mantener su salud. Ya que operamos estrictamente con donativos, pedimos que nos haga una donación de \$5 para sufragar los costos del manejo de este proyecto.

Anticipadamente le agradecemos su donativo en el sobre adjunto.

Nombre del Paciente: \_\_\_\_\_

Numero de Indentification del Paciente: \_\_\_\_\_

Doctor: \_\_\_\_\_

Fecha: \_\_\_\_\_

Remita el sobre a:  
DCMS Foundation  
P.O. Box 4680  
Dallas, TX 75208

Preguntas- llame al 214-413-1425.

¡Gracias por permitirnos servirle!





PAD#

**COMMUNITY HEALTH NAVIGATION EPISODIC REFERRAL FORM**

(Use this for Project Access patients who did not get screened into health navigation/care coordination at the time of PAD enrollment.)

Patient's name: \_\_\_\_\_ Patient DOB: \_\_\_\_\_ Date: \_\_\_\_\_  
Patient's address: \_\_\_\_\_ Zip: \_\_\_\_\_  
Patient's phone number(s): \_\_\_\_\_ OR \_\_\_\_\_  
Person referring patient: \_\_\_\_\_ Organization: \_\_\_\_\_

When/ how often do you want us to report back to you: \_\_\_\_\_  
Best method to use in reporting to you: Fax Phone E-mail Mail Other  
Please provide us with the necessary contact information for the method you have selected:

Over the next 30days what are your expectations as to our contact with this patient?

- One phone call                      One face-to-face visit at our clinic                      One home visit
- 2-3 phone calls                      2-3 face-to-face visits at our clinic                      Two home visits

Other: \_\_\_\_\_

Is there any other additional information that would be helpful in working with this patient?

\_\_\_\_\_  
\_\_\_\_\_

Why are you referring this patient for health navigation? Project Access compliance/adherence Re-enrollment  
 Medication assistance Translation assistance Missed medical appointments Transportation assistance  
Provide medical information for on-going health concern  Referrals/applications for government or community resources  
Other: \_\_\_\_\_

\_\_\_\_\_

\*\*\*\*\*

**Community Health Navigator Use Only:** Nikki Edd Freddie Gloria Irene Jessica Johnny Marina Mari

AM AM AM

One phone call: Time \_\_: \_\_PM Date:            2-3 phone calls: Time \_\_: \_\_PM Date:            Time: \_\_: \_\_PM Date:

No Answer-----Line Busy-----Not a Working #-----Left Call back #----- Left Message with relative-----

One home visit: Date:                      Time: \_\_: \_\_Am/ Pm                      Two home visits: Date:                      Time: \_\_: \_\_AM/ PM  
Date:                      Time: \_\_: \_\_AM / PM

One face-to-face visit at our clinic: Date:                      2-3 face-to-face visits at our clinic: Date:                      Date:

NOTES: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**FAX THIS FORM TO PAD COMMUNITY HEALTH NAVIGATION AT 214-824-8510**





## Project Access Dallas Physician Volunteer Sign-up

There are several options available. Most Primary Care physicians accept up to 5 or more patients per year and manage their care throughout the year (or as long as they qualify for enrollment in Project Access). Specialty Care volunteers will see a patient once or twice, so they usually accept up to 10 or more patients per year. *However, the choice is yours and we are grateful for whatever level of participation you decide.*

**Yes, I will volunteer my time to Project Access. I will donate my time as a:**

**Primary Care Volunteer:** The number of patients I will treat each year is \_\_ 5 \_\_ 10 \_\_ Other

**Specialty Care Volunteer:** The number of patients I will treat each year is \_\_ 12 \_\_ 15 \_\_ 20 \_\_ Other

Prefer not to see patients in my office, but would be willing to volunteer at a community clinic \_\_\_\_\_

*To allow seamless care coordination in the medical treatment of the patient, please provide the following:*

Name: \_\_\_\_\_

Specialty: \_\_\_\_\_ Texas License #: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Tel: \_\_\_\_\_ Fax: \_\_\_\_\_

DEA #: \_\_\_\_\_ NPI #: \_\_\_\_\_

Name and phone # of person to contact in your office:

Name of the ancillary providers you use (X-rays, imaging centers):

If you are a specialty provider who uses anesthesia services, which one do you refer to?

What hospital affiliations are you with?

Primary: \_\_\_\_\_ Secondary: \_\_\_\_\_

How did you hear about Project Access Dallas?

\_\_\_\_ *Please contact me. I have additional questions regarding my role in Project Access Dallas*

***FAX this page to PAD at 214-941-3351. No cover needed.***

