Housecall Providers Referral Form

Referral Guidelines and Process

1. Medicaid members only: **(CareOregon OHP, COA Dual, OHSU IDS, Legacy/PacificSource)** referral for Housecall Providers services (select one): ☐ Advanced Illness Care (Palliative Care) ☐ Primary Care
2. **Fax Referral Form to (503) 416-1323, Attn: HCP Intake**

Referral Contact Information

Name of person completing form:_____Date:_____

Phone #:_____Email Address: _____

Is the patient/provider interested in home based primary care? ☐ Yes ☐ No ☐Unknown

Referral from: ☐ Hospital ☐ CareOregon PHP Program ☐ Clinic, Name: _____

☐ Advance Health ☐ Other: _____

Please include the following information with referral:

- Recent clinician chart/case notes and labs
- Admission H&P/Discharge summary from recent hospitalization
- Current medication list, including allergies
- Current advanced directive/POLST

Patient Information

Patient Name: _____ DOB:_____

SS#_____ CareOregon ID#_____

Phone #:_____☐ Home ☐ Mobile ☐ Other: _____

Alternative Contact Name:_____Relationship:_____

Alt Phone #_____☐ Home ☐ Mobile ☐ POA/Guardian: _____ ☐ Other: _____

Interpreter Needed: ☐ No ☐ Yes, Language: _____

Instructions on how best to contact the patient: _____

_____

County of Residence: ☐ Clackamas ☐ Multnomah ☐ Washington

Patient Address: _____

Residence Type: ☐ Private Home/Apt. ☐ RCF/ALF ☐ Group Home ☐ Adult Foster Home ☐ SNF/ICF

☐ Other:_____

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Housecall Providers
Part of the CareOregon Family

CareOregon

Referral Information

Reason for Referral:

_____

_____

_____

Have you personally discussed this referral with the member or responsible party? ☐ Yes ☐ No

Primary Diagnosis:

_____

Is the patient aware of their diagnosis and prognosis: ☐ Yes ☐ No ☐ Unknown

Co-existing Disease or Complications:

_____

_____

Psychosocial/Safety concerns:

_____

_____

Care Team Information:

PCP: _____ Phone #

_____ Clinic: _____ PCP is aware of referral? ☐ Yes ☐ No

Specialist: _____ Phone # _____

Clinic: _____ Specialist is aware of referral? ☐ Yes ☐ No

Specialist: _____ Phone # _____

Clinic: _____ Specialist is aware of referral? ☐ Yes ☐ No

Pharmacy: _____ Phone: _____

Please include any information that will help with outreach and support of this patient:

_____

_____

_____

_____

If you are uncertain of eligibility or if you have any questions, please call (971) 202-5504