Rhode Island HEALTH **Continuity of Care Form: Consultation/Referral Form**

Patient Name:______________________ Date completed:__________

Attending Physician:______________________ Phone:________

Responsible party:______________________ Phone:________

Relationship:____________ Guardian: ☐ Yes ☐ No POA ☐ Yes ☐ No

Facility/Residence Address:______________________

____

Agency Contact Person:______________________ Phone:________

Medicaid #:____________ Medicare #:__________

Other Insurance:______________________

Patient referred to:______________________

Reason for visit/consult/transfer

☐ Annual Exam ☐ Follow-up ☐ Acute:______________________
(Specify)

☐ Consult/referral ordered by:______________________

Does the patient have an Advanced Directive?

☐ No ☐ **Yes** ☐ Full DNR ☐ Partial DNR

Tuberculin Status – if known:

☐ Negative ☐ Positive ☐ Unknown

Active Infections

	Positive Culture	Active Infection	Date Resolved	Prior History
MRSA				☐
VRE				☐
C.Diff.				☐

Information attached: ☐ Demographic/Face Sheet ☐ Advanced Directive ☐ Diagnosis/Problem List ☐ Medication Sheet ☐ Recent X-ray or Lab

DESCRIPTION OF PROBLEM:

Expectation for situation - ☐ **Long-term problem** ☐ **Short-term problem**

CONSULTATION NOTES (continue on attachment as needed):

Recommendations/orders for the medical necessity of continuance of professional care as specified

Documents attached: ☐ Additional Notes & Diagnosis ☐ New Test Results ☐ New Prescription(s)/Orders

☐ Skilled Nursing Care
☐ Respiratory Therapy ☐ Physical Therapy
☐ Occupational Therapy ☐ Speech Therapy

Follow-up visit required ☐ Yes ☐ No

Appointment date/time:______________________

______________________ PRINT attending physician's name ____________ *Phone* ____________ *Date*

ORIGINAL to – Agency/Patient | COPY to – Physician(s)/Agency | COPY - Chart