Housecall Providers Outpatient Referral Form

Housecall Providers

CareOregon

Referral Guidelines and Process

1. CareOregon member (COA Plus & HSO/CO OHP only) referral for Housecall Providers services (select one): ◯ Advanced Illness Care (Palliative Care) ◯ Primary Care ◯ Hospice ◯ Unknown
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 Phone: _____

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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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:

_____

_____

_____

_____

_____