Physicians CareConnection
An affiliate of the Columbus Medical Association

Physicians CareConnection Referral Form

Today's Date _____

Name of Patient _____
(Last) (First) (Initial)

Street Address _____ **Telephone (home)** _____

City _____ **State** _____ **Zip** _____ **Telephone (alternate)** _____

Date of Birth _____ **Residency Status:** □US Citizen □Permanent Resident □Non-Immigrant Visa □Student

Insurance Status: □None □Medicaid □Medicare □ Private Insurance □VA Benefits **Gender:** □Male □Female

Referred from _____
(Private Practice, Clinic, Hospital, Social Service Agency)

Is this patient enrolled in the Voluntary Care Network? ____Yes ____No

Does this patient require an interpreter? ____Yes ____No **If yes, what language?** _____

If this patient requires an interpreter, please list the contact information of someone who speaks English so that we are able to make initial contact with the patient to coordinate their care.

Name _____ **Telephone Number** _____

REFER TO SPECIALTY (UNINSURED PATIENTS ONLY), PLEASE MARK ALL THAT APPLY BELOW

__ Cardiology
__ Dermatology
__ Dental
__ Gastroenterology
__ Neurology
__ Nutrition
__ Ophthalmology
__ Optometry
__ Physical Therapy
__ Primary Care
__ Pulmonary
__ Urology
__ Mental Health (PMHNP)

PLEASE ATTACH THE FOLLOWING
Problem List, Medication List, Recent Labs, and/or Diagnostic test reports appropriate for this referral.

Reason for Referral:

_____

_____

_____
Physician Signature/Date

_____
Staff Scheduling Referral (please print) **Phone Number**

REFER TO PATHWAYS NAVIGATION PROGRAM (MEDICAID PATIENTS ONLY), PLEASE MARK ALL THAT APPLY

__Diabetes (United HealthCare Community Plan ONLY)
__Pregnancy (Buckeye, CareSource, Paramount, United HealthCare Community Plan ONLY)

_____
Staff Scheduling Referral (please print) **Phone Number**

Please fax COMPLETED REFERRAL to the PCC office at (614) 884-0123