Accountable Care Coalition of Georgia
Established by Georgia Healthcare Systems, Inc.

Date: ____/____/_____

Care Coordination Request Form

PATIENT BACKGROUND:

Patient Name	Patient HIC#
Patient Address	Physician Name
Patient Phone	Physician Phone
Patient Birth Date	Emergency Contact/Caregiver Information

DIAGNOSIS:

☐ Diabetes ☐ COPD ☐ CHF ☐ CAD

☐ Other_______________________________________

Special Instructions_______________________________

____

Date of Last Physician Appointment ____/____/_____

Next Physician Appointment ____/____/_____

REASON FOR REQUEST: INPATIENT

☐ **Admitted to Hospital**

Admission Date ____/____/_____

Hospital Name _____________________________

Hospital Phone (_____) _____ – ________

☐ **Admitted to LTAC/SNF/LTC**

Admission Date ____/____/_____

Facility Name _____________________________

Facility Phone (_____) _____ – ________

☐ **Inpatient Discharge Follow Up**

Discharge Date _____________________________

Discharge Diagnosis ___________________________

☐ **Frequent ER Admission**

☐ **Frequent OBS/Inpatient Stay**

REASON FOR REQUEST: OUTPATIENT

☐ Outpatient Procedure/ Services Follow Up

☐ Additional Health Education Needed

☐ Identified at Risk

☐ Non-Adherence

☐ Other____

____

REASON FOR REQUEST: MISCELLANEOUS & SOCIAL NEEDS

☐ **Care Coordination with Specialist**

Specialist Type _____________________________

Specialist Name _____________________________

Specialist Phone (_____) _____ – ________

☐ **Community Resources**

☐ **Social/Family Support Assessment**

Comments: ___________________________________

____

____

Referring Staff member ________________________

Staff Member's Preferred Method of Contact and Contact info: ______________________________

____

CONFIDENTIAL: This facsimile message and its contents are or may be legally privileged and confidential information intended solely for the recipient. You are hereby notified that any dissemination, distribution, copy or other use of this message or its contents is strictly prohibited. If you have received this facsimile in error, please notify us immediately by telephone at 1-855-243-7309 and return the original message to us at 4888 Loop Central Drive, Suite 700, Houston, TX 77081 via the United States Postal Service and destroy all electronic and hard copies of this communication, including any attachments.

FAX TO: 1-866-867-8712