Continuity of Care **Consultation and Referral Form**

Use this form when patient goes to a scheduled assessment, evaluation, or procedure at another facility.

Patient Name: Date Completed:

Attending Physician: Phone: ( ) -

Responsible Party: Phone: ( ) -

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

Facility/Residence Address:

Agency Contact Person: Phone: ( ) -

Does the patient have:

☐ MOLST ☐ DPA ☐ DNR

Please attach a copy of these forms

Reason for visit/consult/transfer:

☐ Annual Exam ☐ Follow-up ☐ Acute:*(specify)*

☐ Consult/referral ordered by:

Isolation/Precautions

	Positive Culture	Site	Date Resolved	Prior History
ESBL				
CRE				
TB				
MRSA				
VRE				
C.Diff.				

Description of Problem

Information attached:

☐ Diagnosis/Problem list ☐ Medication sheet ☐ Recent X-ray or lab results

Consultation Notes

Documents attached: ☐ Additional notes and diagnoses ☐ New test results ☐ New prescription(s)/orders

☐ Skilled nursing care ☐ Respiratory therapy ☐ Occupational therapy ☐ Physical therapy ☐ Speech therapy

Follow-up required ☐ Yes ☐ No Appointment date/time:

PRINT attending physician's name: Phone: ( ) - Date:

ORIGINAL: Agency/patient COPY: Physician(s)/agency COPY: Chart

A copy of this Record must be transmitted to/with agency/patient and physician.