Rev 06/01/2022

# Care Coordination Referral

| | |
|---|---|
| FROM: | PHONE: |
| FAX: | FACILITY NAME: |

| | |
|---|---|
| PATIENT NAME: | PHONE: |
| ADDRESS: | DOB: |
| D/C DATE: | INCOME/SOURCE: |

DX:

PLEASE CHECK SERVICES NEEDED:

HOUSING: ☐ TRANSPORTATION: ☐ CARE COORDINATION: ☐

FINANCIAL RESOURCES: ☐ OTHER: _____

Whats going on with the client?:

CLIENT AUTHORIZATION:

I AUTHORIZE ONE STOP HEALTH SHOP LLC to contact said client regarding services and to receive any/ all medical information that is pertinent helping client in achieving desired outcome

SIGNATURES :_____ DATE:_____

CHECK ALL THAT ARE INCLUDED:

DEMO: ☐ H&P: ☐ ADMISSION NOTES: ☐

LABWORK ☐ MD NOTES: ☐ 1823 ☐ MEDICATION ☐ INCOME ☐

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