**COMMWELL HEALTH**

Please check service(s) needed:

🞏 Case Management

🞏 Medical/ID

🞏 Dental

🞏 SPNS

**SPNS**

**PATIENT REFERRAL FORM**

**PATIENT DEMOGRAPHICS**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  First | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Middle | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Last | |
| Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | |
| City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | State:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | Zip:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | Sex:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | SS#:\_\_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_ | |
| Home Phone#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | Work Phone#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| 🞏 Married | 🞏 Single | 🞏 Separated | | 🞏 Divorced | | 🞏 Widowed | |
| 🞏 Insurance | 🞏 Medicaid | 🞏 ADAP-please include Case # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |

Do you have access to text? 🗖 Yes 🗖No

Do you have an email address? 🗖Yes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 🗖No

Can we leave a message either on an answering machine or with another person answering your phone?

🗖Yes 🗖No

🗖Yes, but only leave message at (specify) 🗖1 🗖2

Can we send mail to you? 🗖Yes 🗖No

**PRIMARY CARE PHYSICIAN**

|  |
| --- |
| Primary Care Physician:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Agency Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Telephone#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**CASE MANAGER**

|  |
| --- |
| Case Manager:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Agency Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Telephone#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**REFERRAL SOURCE**

|  |
| --- |
| Referred By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Agency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Telephone#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Fax#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Clinic Contact Person:**

**Network Navigator**

**CommWell Health**

**3331 Easy Street**

**Dunn, NC 28334**

**Telephone #: 910-567-6194**

**Fax #: 910-567-5678**

|  |
| --- |
| Office Use Only: Date Referral Received: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Initials: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**UF CARES/River Region PATH Home Project**

**Partnership for Access to Treatment and Housing (PATH HOME) HIV/Homeless SPNS**

**Screening Referral Form**

Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last known location of client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Yes or No

1. Is this client HIV Positive? Diagnosis date \_\_\_\_\_\_\_\_\_\_\_ ⃝ ⃝
2. Is this client lost to care 6 months or more? ⃝ ⃝
3. Is this client pregnant? ⃝ ⃝
4. Is this client homeless? ⃝ ⃝

If yes, since when \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Does this client have unstable housing? ⃝ ⃝

If yes, since when \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Has this client been released from prison/jail in the past 6 mths? ⃝ ⃝
2. Has this client been released from the hospital in the past 3 mths? ⃝ ⃝
3. Does the client have a substance abuse history? ⃝ ⃝

If yes, drug of choice & last use \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Does this client have a Mental Health history? ⃝ ⃝

Diagnosis and when \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If yes, please assess the following:

1. Is client able to verbally describe the purpose of the study? ⃝ ⃝
2. Is client able to verbally describe risks and benefits? ⃝ ⃝
3. Is client able to verbalize understanding that they would

not lose services whether or not they participated? ⃝ ⃝

1. Is client able to verbalize understanding of his/her rights

to withdrawal consent and terminate participation? ⃝ ⃝

1. Is client able to verbalize right to refuse to answer questions? ⃝ ⃝

If client is unable to accurately respond to above questions, the client should not be consented into the study until a referral and assessment is made by the psychologist to determine capacity to participate in the study. **STOP**

1. Is the client on any current medications? ⃝ ⃝

If yes, medication names \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Has this client ever been diagnosed with AIDS? ⃝ ⃝

If yes, when \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referred by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Agency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please fax completed referral to: [Staff Name] @ 904-XXX-XXXX

**UF CARES/River Region PATH Home Project**

**Referral form for Housing, Mental Health, and/or Substance Abuse**

Patient Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone #/Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Current housing situation is HOMELESS or UNSTABLE?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Mental Health HX (what, when, & where)?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Substance use history (what & when) in past 12 months?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. MCM completed (what)?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Pending appointments (when & where)?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Linkage still needed?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Faxed documents to 904-899-6386: POP, CAREWARE FACE SHEET, CURRENT LABS, MAR,\_\_\_\_\_\_\_\_\_\_

Client Case Manager/Agency is \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Completed by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**TITLE: PATH Home Referral and Linkage**

**PURPOSE:** To establish a process for identifying, referring and linkage multiply diagnosed HIV positive individuals to the PATH Medical Home Model.

**POLICY:** Through this 5 year SPNS/HRSA Demonstration Project, “Building a Medical Home for Multiply Diagnosed HIV+ Homeless Populations”, UF CARES in collaboration with River Region and Ability Housing will develop a Medical Home Model for patients who are homeless or unstably housed.

Patients will be identified, referred and linked into comprehensive medical care and provided assistance with housing and other services through intensive case management and referral to an on-site clinic within a housing complex.

As part of the demonstration project, eligible patients may also participate in a multi-site evaluation study to evaluate models of care across nine other demonstration sites.

**PROCEDURE:**

* 1. Eligible patients include the following:
     1. At least 18 years of age
     2. HIV positive, **and**
     3. Homeless, **or**
     4. Unstably housed, defined as
        + Transitional or Supportive housing
        + Assisted living facility or nursing home
        + Residential treatment center
        + Group home
        + Motel/hotel
        + Staying with friends or family
        + Victim of domestic violence, **and**
     5. Mental health diagnosis, **or**
     6. Substance Abuse disorder

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As part of the demonstration project, eligible patients may also participate in a multi-site evaluation study to evaluate models of care across nine other demonstration sites.

**PROCEDURE: Referral to PATH**

* External and Internal referrals are faxed, completed on the PATH Referral form, to the PATH Team attn.: [Staff Name], Medical Case Manager, at 904-XXX-XXXX
* Medical Case Manger has 48 hours to review referral and make contact with the client
* If unable to locate the client, Medical Case Manager will then contact the Referral Source to assist with location of the client
* Once client has been located, Medical Case Manager will screen client to ensure accuracy of referral.
* If client does not meet PATH eligibility, Medical Case Manager will link client to appropriate resources.
* If client does meet PATH eligibility, intake into PATH, including consenting and base line interview, is scheduled with Project Evaluator on shared Outlook calendar within 1 week.
* Once intake has been completed, client is referred back to PATH Medical Case Manger to complete Ryan White forms, consents and eligibility.
* Medical Case Manager ensures initial labs are completed/current and PATH clinic appointment is scheduled.
* Medical Case Manager completes a Needs Assessment and make appropriate referrals to River Region for housing, mental health and substance abuse and needed.
* Medical Case Manager links to Patient Navigator to assist with any needed services and education.
* Medical Case Manager develops client chart and begins initial documentation in CAREWare and notification made to referral source that client has been consented in to the PATH program.