Maine Community Accountable Care Organization
Established by Maine Primary Care Association

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: _________________________________

____

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