



Date: \_\_\_\_\_

### MedStar Family Choice Outreach Services Referral Form

Member Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Sex: \_\_\_\_\_ MSFC ID#: \_\_\_\_\_

Address: \_\_\_\_\_ Phone#: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ Phone#: \_\_\_\_\_

Referral Source: \_\_\_\_\_ Phone#: \_\_\_\_\_

Member PCP: \_\_\_\_\_ Phone#: \_\_\_\_\_

#### REASON FOR OUTREACH REFERRAL

\_\_\_\_\_ Assist/Educate w/transportation to medical appointment      \_\_\_\_\_ Provide information about community-based services for: \_\_\_\_\_

\_\_\_\_\_ Assist/Educate w/location of PCP      \_\_\_\_\_ Assist provider w/scheduling appointment

\_\_\_\_\_ Educate about MCO processes      \_\_\_\_\_ Follow-up on repeated missed appointments List Dates: \_\_\_\_\_

\_\_\_\_\_ Need contact from Special Needs Coord. (please specify reason below)      \_\_\_\_\_ Follow-up on repeated ER usage/educate member to use PCP for care

Other: \_\_\_\_\_

---

#### RESULTS OF MEDSTAR FAMILY CHOICE OUTREACH

(check all that apply)

\_\_\_\_\_ Contact made with member to assist with transportation. The following information was provided to the member: \_\_\_\_\_

\_\_\_\_\_ Contact made with member to assist/educate with location of PCP

\_\_\_\_\_ Home visit completed to follow-up with non-compliant member. Results: \_\_\_\_\_

\_\_\_\_\_ Referral to the Local Health Dept ACCU for non-compliance; Date sent: \_\_\_\_\_

\_\_\_\_\_ Medical Appointment scheduled for Member: Date: \_\_\_\_\_ Provider: \_\_\_\_\_

\_\_\_\_\_ Referral to community-based program; Contact person/phone number: \_\_\_\_\_

\_\_\_\_\_

Other: \_\_\_\_\_

Outreach Representative: \_\_\_\_\_ Phone: \_\_\_\_\_