APPENDIX E

CLINICIAN REFERRAL/ORDER FORM – Community Team-Based Care Program for Chronic Disease Management
(Physician, Physician Assistant, or Advanced Practice Registered Nurse)

Fax Form to: Poinsett County Health Unit: 870-578-4480

Today's Date: _____

Client's Name: _____ Date of Birth: _____
First MI Last

Address: _____ Preferred Phone: _____

Baseline Client Information at Referral: BP _____ Height _____ cms. Weight _____ lbs.

Care Manager referral for (check all that apply): Hypertension _____Diabetes _____

Current Medications: _____

_____

Pharmacy Name & Phone Number: _____

Care Management for (check all that apply): Diet/Physical activity _____ Medication adherence __

Self-monitoring of blood pressure/blood glucose _____ Other (please specify) _____

Notify me if Systolic BP is over _____ or Under _____

Notify me if Diastolic BP is over _____ or Under _____

To be seen in my office on (Date): _____

Clinician Name/Credentials (Print): _____ Office Phone: _____

Clinician Signature: _____ Office Fax: _____

Additional comments/instructions for the Care Manager

_____

For questions, contact Care Manager: Belinda Stillwell
Phone: 870-578-4480