Revised 11.12.2009v5

High Risk Management & Primary Care Home Visit Program

Referral Form

Please complete referral form and fax to American Canyon House Calls at **707.552.3288**.
For urgent referrals, please call the number listed below for immediate intake and scheduling.

PARTNERSHIP HEALTH PLAN OF CALFORNIA:

☐ **ADVANTAGE** **ID#** ____________________

☐ **MEDI-CAL** **ID#** ____________________

American Canyon House Calls: *Contact Information*

FAX Number for Intake	707.552.3288	**Edwina Hanna-Reese, NP**	707.483.8313
Phone Number for URGENT Referrals	707.554.4704		

Referred By: Name: ____________________ Phone Number: ____________________

(if not PHC CM) Address: ____________________

City: ____________________ Zip Code: ____________________

Emergency Priority: *(urgent, needs to be seen today)* **1 2 3** *(routine, can be scheduled in 1-2 weeks)*

Personal Information

Client's Name: ____________________

SS#: ____________________ **DOB:** ____________________

Home Phone #: ____________________ **Cell Phone:** ____________________

Emergency Contact/POA : ____________________ **Phone:** ____________________

Address: ____________________

City: ____________________ **Zip Code:** ____________________

PCP Name: ____________________ **PCP Phone:** ____________________

Diagnosis: ____________________ **Risk Category:** ☐ **High** ☐ **Mod** ☐ **Low**

Reason for Referral: ____________________

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Patient currently in: ☐ **Home** ☐ **B&C Facility** ☐ **Assisted Living** ☐ **SNF** ☐ **Hospital** ____________________

Referral Contact Information

PHC Case Manager: ____________________ **Phone #:** ____________________

Signature/Approval: ____________________ **Date:** ____________________

(Please attach any relevant clinical information if available.)