TSCN REFERRAL FORM (Beta)

A physician guild supporting coordinated patient care

FROM DOCTOR:

First name

Last name

Specialty

Phone #

Practice / clinic name

Doctor email

TO TSCN CARE COORDINATORS:

PATIENT INFORMATION

Patient first name

Patient last name

Date of birth (MM / DD / YYYY)

Cell phone

Patient email

Street address / apartment

City

State

ZIP code

Documents enclosed (check all that apply):

- ☐ Clinical notes
- ☐ Test / imaging reports
- ☐ Signed HIPAA authorization
- ☐ Other: _____

Attach copies of relevant documents when returning this referral.

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Patient name (repeat for page identification)

Date of birth

REFERRAL TO Details

☐ TSCN Referral Engine

☐ Refer to Dr. (complete below)

Receiving doctor first name

Receiving doctor last name

☐ Doctor is a TSCN member

☐ Doctor should be invited to join

Specialty requested

Patient will return to me when done: ☐ Yes ☐ No ☐ N/A

Reason for referral / clinical question

Referral notes / urgency / documents enclosed

Priority: ☐ Routine ☐ Urgent

For urgent coordination, text the intake coordinator at (201) 819-0484.

PATIENT UNDERSTANDING & REFERRER SIGNATURE

I joined TSCN so my patients can have care coordinators. Your care coordinator can help resolve problems during care coordination and contact me when needed.

Patient understands this care coordinator role:

☐ Yes ☐ No ☐ Not yet discussed

Referring doctor signature

Date

Return completed referral: scan both pages and email to support@tscn.care.