# HUB REFERRAL FORM

*HUB's mission is to improve the health of those with diabetes and/or hypertension, reduce risks by offering education & support and to ensure participants have a medical home*

| | |
|---|---|
| **From:** (Referring Agency) | Fax: |
| Referrer's Name & Title: | Telephone: |

## Client/Patient Information

| | |
|---|---|
| **Name:** | Telephone: |
| Address: | DOB: |
| Email: | Primary Language: |

## Provider Information:

| | |
|---|---|
| **PCP Name:** | **Address:** |
| **PCP Telephone:** | **PCP Fax:** |
| **Office Contact:** | |
| **Communication Preferences (i.e. telephone, email, fax):** | |

## Client/Patient History

**Medical History:**

**Current Medications:**

**Allergies:**

**Recent Laboratory Results:**

Insurance Coverage *(none; pending; if yes, include name of coverage and ID number*):

*Insurance is not required but needed for referrals (i.e. dental, vision, DME, etc.)*

## Diabetes ____ HTN ____

**Reason for Referral: (check all that apply): _____ HGB A1C (=/>7) _____Mean Arterial Pressure (>90)**
**_____ Missed Appointments _____Missed Medication pickup-Last pickup_____**

## FAX FORM & DOCUMENTS TO 757-690-8974 (HIPAA Compliant)

## FOR OFFICE USE ONY

**Eligible? ____ Yes _____No Date Faxed to HUB: Coordinator:**

***Healthy Chesapeake & Collaborative partners working together to improve the health status of Chesapeake residents***