MedStar Family Choice

Date:_____

District of Columbia Healthy Families
&
DC Healthcare Alliance

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

_____Assist/Educate w/location of PCP

_____Educate about MCO processes

_____Need contact from Special Needs Coord. (please specify reason below)

_____Provide information about community-based services for:_____

_____Assist provider w/scheduling appointment

_____Follow-up on repeated missed appointments
List Dates:_____

_____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:_____

Medstar Family Choice Outreach Fax Number: 202-243-5496