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| **<CHW Program Here and logo>****Patient Referral and Plan of Care** | **<Program Address>****<Program Phone Number>***Please direct any questions or concerns to <name>* |
| **Date Order Written: \_\_\_\_\_\_\_\_\_\_** |
| **Patient Information:** |
| Patient Name: |  | Date of Birth: |  |
| Gender: | \_\_ Male \_\_ Female \_\_ Other | Phone: |  |
| Address: |  |
| **Referring Provider Information:** |
| Provider: |  | Provider NPI: |  |
| Additional Providers: |  |
| **Provider Orders for CHW Services:** |
| **Qualifying Condition(s):** *(Please check all that apply, if applicable)* |
| \_\_\_ Asthma\_\_\_ Cancer\_\_\_ COPD\_\_\_ Depression\_\_\_ Diabetes\_\_\_ Heart Disease\_\_\_ Hypercholesterolemia\_\_\_ Hypertension\_\_\_ Mental Health Conditions | \_\_\_ Musculoskeletal and neck/back disorders\_\_\_ Obesity\_\_\_ Prediabetes\_\_\_ High Risk Pregnancy\_\_\_ Substance Use Disorder\_\_\_ Tobacco use\_\_\_ Use of multiple medications (6 or more)\_\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. |
| **Qualifying Barrier(s):** *(Please check all that apply, if applicable)* |
| \_\_\_ Geographic Distance from health services\_\_\_ Lack of phone *(Seeking care at incorrect location)* | \_\_\_ Cultural/language communication barriers\_\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.  |
| **CHW Objectives:** |
| \_X\_ Assess and assist with social determinants of health needs as related to qualifying condition(s) and/or qualifying barrier(s).\_X\_ Provide health system navigation and resource coordination as related to qualifying condition(s) and/or qualifying barrier(s).\_X\_ Provide health promotion and coach regarding qualifying condition(s) and/or qualifying barrier(s) and subsequent social determinants of health needs.\_X\_ Provide health education regarding qualifying condition(s) and/or qualifying barrier(s) and subsequent social determinants of health needs.Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **CHW Services:** |
| \_X\_ Health system navigation and resource coordination \_X\_ Health promotion and coaching \_X\_ Health education to teach or promote methods and measures that have been proven effective in avoiding illness and/or lessening its effects. |
| **Frequency and Duration of Services:** |
| Work with patient up to \_4\_ units per day (a unit is defined as 30 minutes) with a maximum of \_20\_ units per week. Assess CHW services after six months, or prior if patient is ready to be discharged from CHW services. Care plan must be reviewed, at minimum, every six months. |
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| **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_** **Provider Signature Date** |
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**Once completed, please fax to:**

**<605-123-4567> Attn: CHW Program**