Cross Plains Area EMS

Care Connect -- Community EMS Program

FORM CC-02Q
Quick Referral Sheet
Rev. April 2026

CARE CONNECT -- QUICK REFERRAL SHEET

Submit via: Fax: 608-798-1839 Secure Email: chief@crossplainsems.com Phone: 608-798-2720
Questions? Contact the Care Connect Coordinator.

A -- Referring Party

Your Name | *Title / Role*

Organization / Agency | *Phone*

Email or Fax (for follow-up) | *Date of Referral*

Referring as:

- □ Physician / Clinic
- □ Social Services / ADRC
- □ Behavioral Health Provider
- □ Community Organization
- □ Hospital / ED Discharge
- □ Law Enforcement / Fire
- □ Family / Caregiver
- □ Self-Referral / Other

B -- Patient Information

Patient Full Name | *Date of Birth*

Home Address | *City / ZIP*

Primary Phone | *Alternate Phone* | *Best Time to Call*

Lives:

- □ Alone
- □ With family / caregiver
- □ Group home / assisted living
- □ Unstable / unknown

C -- Reason for Referral & Priority

Response Priority:

☐ URGENT	☐ ROUTINE	☐ SCHEDULED
Within 24 hrs	*Within 72 hrs*	*Coordinate time*

Primary Reason (check all that apply):

- ☐ Frequent 9-1-1 caller
- ☐ Fall risk / recent fall
- ☐ Medication concerns
- ☐ Substance use concern
- ☐ Post-ED -- no PCP follow-up
- ☐ Caregiver support needed
- ☐ Recent hospital discharge (< 30 days)
- ☐ Chronic disease -- poor management
- ☐ Behavioral / mental health
- ☐ Social needs (food, housing, transport)
- ☐ Elderly / isolated
- ☐ Other: _____

Brief reason for referral / key concerns (2-3 sentences):

(continued if needed)

D -- Clinical Snapshot (share what you know -- patient will complete enrollment details at first visit)

Patient's Primary Care Provider (PCP)

PCP Phone

Does the patient have a PCP?

☐ Yes ☐ No -- help establishing one is needed ☐ Unknown

Key diagnoses / conditions (optional):

- ☐ CHF
- ☐ Diabetes
- ☐ Dementia / Cognitive Impairment
- ☐ Substance Use (AODA)
- ☐ Cancer
- ☐ Palliative / Hospice
- ☐ COPD / Asthma
- ☐ Hypertension
- ☐ Depression / Anxiety / Mental Health
- ☐ Recent Surgery / Procedure
- ☐ Mobility / Fall Risk
- ☐ Other: _____

Any safety concerns for visiting staff?

□ No known concerns
□ Aggressive behavior / weapons
□ Unsafe pets
□ Other: _____

Safety details (if checked above):

E -- Privacy & Signature

HIPAA Notice: Clinical referrers (physicians, hospitals, care coordinators) may share patient information for care coordination under HIPAA 45 CFR 164.506 (TPO) without additional authorization. Non-clinical referrers (law enforcement, community organizations, family) should share only the minimum necessary information -- name, contact, and reason for referral -- unless the patient has signed an authorization (Form CC-01). Care Connect staff will obtain full consent at the initial visit.

Check one:

□ Clinical referrer -- sharing under HIPAA TPO
□ Non-clinical referrer -- sharing minimum information only (no PHI)
□ Patient authorization attached (Form CC-01)
□ Other: _____

Is the patient aware of this referral?

□ Yes -- agreeable □ Yes -- hesitant □ Not yet informed

Referring Party Signature *Date*

Printed Name *Organization*

OFFICE USE ONLY

Received By	Date / Time	Assigned To	Enrollment Status
			□ Enrolled □ Pending □ Declined

Notes:

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