The Joint Works Program

Care Transitions Referral

Frederick Health

DATE OF REFERRAL | PRIMARY CARE PHYSICIAN

Patient Information

LAST NAME | FIRST NAME | MIDDLE | DATE OF BIRTH

DAYTIME PHONE # | ALTERNATE PHONE #

CONTACT PERSON NAME | PHONE #

ADDRESS | CITY | STATE | ZIP

Diagnosis: _____

Reason for Referral

☐ Safety and ability to remain in home or return home after a hospitalization or surgery

☐ Lives alone and needs to discuss options for providing supervision for safety when discharged home after hospitalization or surgery

☐ Financial concerns about ability to pay for medications, medical treatment, etc.

☐ Transportation to and from medical appointments, surgery, equipment etc.

☐ Medication Management ☐ Community Resources ☐ Education ☐ Other _____

Comments: _____

REFERRAL MADE BY | PHONE #

Please call or fax referrals to:
Frederick Health Care Transitions
PHONE: 301-360-2574
FAX: 240-566-7865

Please include patient's current medication list and any recent office notes with referral if possible.