REACH
Resource Equity & Access Coordination Hub

REFERRING FACILITY DETAILS:

Caller Name: _____

Referring Facility: _____

Unit Phone #: _____

Referring Provider Full Name (MD, NP, PA): _____

Referring Provider # if not on unit: _____

Patient's current level of care:
☐ ED or ☐ Inpatient

If ED, ED Arrival date/time: _____

If Inpatient, is the Patient:
☐ Observation or ☐ Inpatient

When connecting orgs to your facility for patient info, would you like us to ask for the RN or the provider? ☐ RN or ☐ Provider

PATIENT DEMOGRAPHICS:

Patient First & Last Name: _____

DOB: _____

Gender: ☐ Female ☐ Male

Eligible for placement at IHS or VA?
☐ IHS ☐ VA ☐ None

CLINICAL INFORMATION:

Primary diagnosis for transfer: _____

Medical Service/Specialists needed for transfer: _____

EMTALA reason for transfer: _____

Isolation Requirements: _____

Any continuity of care (if yes, provide name of provider & specialty): _____

Any special care needs (Dialysis, sitter, incarcerated, bariatric bed, transplant history, etc.)? _____

Requested level of care: _____

Have you contacted any facilities/organization for placement of this patient? _____

If so, please specify and clarify if they are actively working on placement _____

Preferred Destination for placement:

Specific organization placement requests: _____

In state only or is out of state placement, ok? _____

If in state only, is the patient willing to go anywhere within the state? _____

Are you willing to waitlist or only target facilities with available capacity? ☐ Waitlist ok or ☐ Capacity only

If waitlist, how many attempts? _____ How long in between attempts? _____

Phone: (602) 827-2093
Fax: 602-827-7078