Transition of Care/Continuity of Care Request Form
(This must be completed by Provider)

Physician MPID/ID: _________________________________

Physician Name: ___________________________________ Phone Number: (____) ______- _______

Address: ____________________________ City: ________________________ State: _____ Zip Code:____

Date of Patients Last Visit: ____/_____/____ Frequency of Patients Visits, ex. Daily, Monthly:________

Date of Patients Next Scheduled Appointment: ____/_____/_______

Diagnosis: ____Expected Length of Treatment: ____________

Is the patient in their second or third trimester of pregnancy? ______Yes ______No

If Yes, Expected Delivery Date: ____/_____/_______

Is the patient in their postpartum period of pregnancy? ______Yes ______No

If yes, delivery date: ____/_____/_______

Is the patient in active treatment for a chronic or acute medical condition?

Chronic Condition: ______Yes ______No

A medical condition due to disease, illness or other medical problem or disorder serious in nature and continues without cure, worsens over an extended period, or requires ongoing treatment to maintain in remission or prevent deterioration.

Acute Condition: ______Yes ______No

A medical condition, more serious in nature, with a sudden onset of symptoms due to injury, illness, or other medical problem requiring prompt medical attention for a limited duration. Examples of Acute Condition include acute infections such as pneumonia or cellulitis, acute cholangitis or pancreatitis, heart attack or stroke.

Current/Proposed Treatment: ____

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Physician Signature: ____ Date: ____/____/____