

The GUIDE Model

Physician or Agency Referral Form

Please complete all applicable sections and submit to Program Manager: melissa.gerard@providence.org
Questions? Call 707 815 6258

SECTION 1: PATIENT INFORMATION

(Please Print)

Last Name		First Name	Middle Initial
Address		City	State Zip
Preferred Language	<input type="checkbox"/> English	<input type="checkbox"/> Tagalog	DOB
	<input type="checkbox"/> Spanish	<input type="checkbox"/> Other _____	
Primary Diagnosis			

SECTION 2: CONTACT PERSON

Patient (details above) Caregiver/Family Member Legal Representative

Last Name	First Name
Email	Phone
Relationship to patient	

SECTION 3: CONSENT TO CONTACT

I confirm that the patient (or their legal representative) has given permission for GUIDE Program staff to contact the patient or designated contact person for the purpose of care coordination, program eligibility screening, and related services. Yes No

Name of person providing consent	Date
Signature	

SECTION 4: INSURANCE INFORMATION (if known)

Current Coverage (check all that apply):

- Medicare Advantage
- Medicare Supplement (Medigap)
- Medi Cal
- Dual Eligible (Medicare + Medi Cal)
- Other:
- Unknown / Needs assistance verifying coverage

Insurance Plan Name: _____

Medi-Cal #: _____

SECTION 5: REASON FOR REFERRAL (check all that apply)

- Care coordination / navigation
- Support managing chronic conditions
- Social needs support (housing, food, transportation, etc.)
- Caregiver support
- Transitions of care / post hospital support
- Health education and self management support
- Other (please describe): _____

Additional details or clinical context

SECTION 6: REFERRING PROVIDER/AGENCY

Referring Physician/Agency Name

Last Name

First Name

Email

Phone

Preferred Method of Follow-Up: Phone Email

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Providence Community Health Napa Valley - The GUIDE Model Program

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