CONSULTATION REQUEST

Care Management Services

To: GRIPA Intake Staff
Fax #: 585-922-1524 Date________________
Phone #: 585-922-1520

From Provider:____

Office Contact:________________________________Phone:________________

Patient Name:_______________________________________DOB:____________

Insurance Plan: ____

Contract #: (if available)______________________________

Program requested: (please circle)

Diabetes Geriatrics Pharmacy Depression Case Management

Please attach the following:

- √ **Current Diagnosis/Medication list** including over the counter medications, vitamins, supplements, herbs.
- √ **Copies** of **your progress notes** from the last 6-12 months.
- √ **Copies** of letters **sent by consultants** from the last 6-12 months.
- √ Other pertinent psychosocial information that would be helpful.

If you are unable to provide this information, we would be glad to complete a chart review in your office.

Thank you for this referral and we look forward to working with you.

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health care could look like this™

Greater Rochester Independent Practice Association

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