Specialist Return Form

Thank you for participating in Project Access.
Your patient has been assigned a patient navigator who will schedule all appointments and diagnostic tests. We will also help the patient obtain medications and access other treatment recommendations. Please copy Project Access on all correspondence and please fax this form to our office and call us with any questions.

> NOTE: If you need translation services please call the YNHH Interpreter Service at (203) 688-7523 and identify yourself as a Project Access provider serving a Project Access patient and request the desired language.

PLEASE SEND THIS FORM (IMMEDIATELY) AND YOUR CONSULTATION LETTER (WITHIN 1-2 BUSINESS DAYS) TO:

Fax: (203) 773-9711 (Note: we will transmit your consultation letter to the referring provider)

To better coordinate your patients' care; please fill out the following information: Today's Date: __________

Specialist Name:	Referring Provider:
Patient Name: DOB: ________________ Appt.:_______________	Location/Contact:

1. Did the patient show up for their appointment?	[ ] Yes [ ] No
2. Was the patient on time for their appointment?	[ ] Yes [ ] No
3. Is a follow-up appointment needed at your office? Next appointment date: _______________________________	[ ] Yes [ ] No
4. Is a referral to another physician needed? *We will schedule the appointment with a participating Project Access provider*	[ ] Yes [ ] No If yes, to which specialty/ies? ____________________________________
5. Is lab work needed? *Please use request forms from our participating labs: YNHH or HSR*	[ ] Yes [ ] No Preferred date _____________________ Fasting?[ ] Yes [ ] No
6. Are diagnostic imaging tests needed? *Please use request forms from our participating imaging sites: YNHH or HSR* *Note: If you prefer we schedule, please provide a copy of the requisition.*	[ ] Yes [ ] No
[If yes], please describe test and preferred date of test?	Test/Preferred Date:
[If yes], will this test be performed in your office?	[ ] Yes [ ] No
7. Was a new medication or therapy prescribed? *If possible, we will assist patient in accessing medication/therapy.* *IF APPLICABLE, PLEASE FAX A COPY OF THE PRESCRIPTION*	[ ] Yes [ ] No If yes, were samples provided: [ ] Yes [ ] No and/or was a prescription provided: [ ] Yes [ ] No

Prescribed Therapy: Name/Instructions:	Prescribed Therapy: Name/Instructions:
Office Use: Date Received_______________________________	