Local Health Services Request- St. Mary's County Health Department

Date: ______________________________
To: Administration Care Coordination Unit
Fax #: 301-475-9431

From: ________________________________
Phone #:______________________________
Fax#: ________________________________

Client Name: ___________________________
Phone Number: _________________________
Address: _______________________________
____

MA #: _______________________________
DOB: _____/_____/_____
SS #: ________-______-_________
Sex: M F
Hispanic: Y N
Race: African American/Black Caucasian
Alaskan Native Native Hawaiian Asian
American Native Pacific Islander
More than one race Unknown
Marital Status: Single Married Unknown
If interpreter needed, specify language:
____

Emergency Contact: _____________________
Relationship: ___________________________
Phone #: _______________________________

Follow- Up For: (Check all that apply)
__ Children under 2 years of age
__ Child 2-21 years of age
__ Child with special health care needs
__ Pregnant EDD: ____/____/____
__ Adult with disability (mental, physical, or developmental)
__ Substance abuse care needed
__ Homeless (at-risk)

Related To: (Check all that apply)
__ Missed Appointments: __ # missed
__ Adherence to plan of care
__ Immunization delay
__ Preventable hospitalization
__ Transportation
__ Other

Diagnosis: ____
Comments: ____
____
____

Local Health Department
Date Received: ___/___/___ Date Returned: ____/____/____
Reason for Return: __________________
Documented outreach:
Letter: _____ Phone Calls: ____________________________ Face to Face: ________
Disposition:
____ Contact Complete Date: ____/____/____
____ Unable to Locate Date: ____/____/____
____ Referred to: _____________________________ on (Date) ____/____/____
Contact Person: _________________________________ Phone #: 301-475-__________