KAISER PERMANENTE®

TRANSITION OF CARE REQUEST FORM

Request for all Physicians
Send form to:
Attn: Quality Resource Management Dept.
Kaiser Permanente
Nine Piedmont Center
3495 Piedmont Road, NE
Atlanta, GA 30305-1736
FAX #: (866) – 452-4585

Member Name:_____ Health Record Number:_____

Member Address: _____

_____

Member Telephone Number: _____

Date of Request: _____

Type of Request:

Continue with PCP
Continue with OB/GYN
Continue with Specialist
Other

Practitioner Name: _____

Practitioner Address: _____

_____

Practitioner Phone #:_____Practitioner Fax #:_____

TO BE COMPLETED BY PHYSICIAN

1. **Diagnosis:** List the primary, severe or life-threatening medical conditions as well as all pertinent secondary diagnosis. **Please include EDC.** Attach additional sheets or submit narrative report covering all items(2-6) listed below, if necessary:

   _____
   _____

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2. **Treatment**: List all treatment of the above severe or life-threatening medical condition. Please be specific and provide dates of treatment.

Diagnosis	Treatment	Dates of Treatment

3. **Treatment Plan:** Please provide a complete treatment plan for the next 12 months. Include such information as surgeries, medications to be administered, and any protocols that will be followed.

Diagnosis	Treatment	Dates of Treatment

4. **Present Condition:** Please make a brief statement on the present condition of the applicant.

_____
_____
_____
_____

5. **Documentation:** Please attach a copy of any pertinent records including, but not limited to: operative narratives, past treatment records, laboratory results, x-rays and procedure reports.

6. **Other Physician Consultants:** Please list any other physicians who are currently treating this applicant for this condition.

Name	Address	Specialty

APPROVED: **YES** **NO**

_____ _____

Approval Signature **Approval Date**