

**TEXAS HEALTH STEPS
PROVIDER OUTREACH REFERRAL FORM
FAX: 512-533-3867**

- Complete this form and submit by fax.
- Use only ONE FORM PER HOUSEHOLD, up to 2 patients.
- You will receive notification once your referral is processed.

Provider Information

Date:

Provider/Clinic Name:		Contact Name:	
Office Address:	City:	County:	Zip Code:
Phone Number:		Fax Number:	
Provider Type:	<input type="checkbox"/> Medical	<input type="checkbox"/> Dental	<input type="checkbox"/> Orthodontic
	<input type="checkbox"/> Case Management	<input type="checkbox"/> Other:	

Parent/Guardian Information

Parent/Guardian Name:		Phone Number:		Mobile Number:	
Address:		City:	County:	Zip Code:	
Language Preference:		<input type="checkbox"/> English	<input type="checkbox"/> Spanish	<input type="checkbox"/> Other:	

Patient #1 Information

Patient Name:		Date of Birth:		Medicaid ID:	
Appointment Type:	<input type="checkbox"/> THSteps Checkup	<input type="checkbox"/> THSteps Followup	<input type="checkbox"/> Sick Visit	<input type="checkbox"/> Lead	
	<input type="checkbox"/> Other:				
Reason for referral (<i>check all that apply</i>)					
<input type="checkbox"/> Patient missed appointment, date:			<input type="checkbox"/> Assistance needed scheduling appointment.		
<input type="checkbox"/> Follow-up appointment for additional lead testing.			<input type="checkbox"/> Provide updated patient address (<i>Case Management Only</i>)		
<input type="checkbox"/> Assist with transportation to appointment.			<input type="checkbox"/> Other, see comments.		
Comments:					

Outreach Services Results (SSU Use Only)

<input type="checkbox"/> Appointment scheduled; date/time:	<input type="checkbox"/> Patient provided education about appointment etiquette.
<input type="checkbox"/> Patient assisted with transportation to appointment.	<input type="checkbox"/> Patient will contact provider directly.
<input type="checkbox"/> No action taken; patient declined assistance.	<input type="checkbox"/> No action taken; patient no longer eligible for Medicaid.
<input type="checkbox"/> Unable to locate patient; letter mailed to patient.	<input type="checkbox"/> Other:
Comments to Provider:	

Patient #2 Information

Patient Name:		Date of Birth:		Medicaid ID:	
Appointment Type:	<input type="checkbox"/> THSteps Checkup	<input type="checkbox"/> THSteps Followup	<input type="checkbox"/> Sick Visit	<input type="checkbox"/> Lead	
	<input type="checkbox"/> Other:				
Reason for referral (<i>check all that apply</i>)					
<input type="checkbox"/> Patient missed appointment, date:			<input type="checkbox"/> Assistance needed scheduling appointment.		
<input type="checkbox"/> Follow-up appointment for additional lead testing.			<input type="checkbox"/> Provide updated patient address (<i>Case Management Only</i>)		
<input type="checkbox"/> Assist with transportation to appointment.			<input type="checkbox"/> Other, see comments.		
Comments:					

Outreach Services Results (SSU Use Only)

<input type="checkbox"/> Appointment scheduled; date/time:	<input type="checkbox"/> Patient provided education about appointment etiquette.
<input type="checkbox"/> Patient assisted with transportation to appointment.	<input type="checkbox"/> Patient will contact provider directly.
<input type="checkbox"/> No action taken; patient declined assistance.	<input type="checkbox"/> No action taken; patient no longer eligible for Medicaid.
<input type="checkbox"/> Unable to locate patient; letter mailed to patient.	<input type="checkbox"/> Other:
Comments to Provider:	

TEXAS HEALTH STEPS
PROVIDER OUTREACH REFERRAL SERVICES

FAX COVER SHEET

DATE: _____

TO: SPECIAL SERVICES UNIT

PHONE: 877-847-8377

FAX: 512-533-3867

FROM: _____

PHONE: _____

FAX: _____

TOTAL PAGES INCLUDING COVER SHEET: _____

COMMENTS:

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