The Triple-Win Communications System

Each patient referral has four distinct steps. The following form will help you standardize and streamline communication between the referring doctor and the specialist, enhancing the patient experience and resulting in better clinical care.

Step 1: **Referral** *(to be completed by referring doctor)*

Referring Doctor's Name _____

Practice Name _____

Address _____

City _____ State _____ ZIP _____

Telephone Numbers: Practice _____ Cell _____

Email _____ Fax _____

Patient Name _____

Address _____

City _____ State _____ ZIP _____

Telephone Numbers (Check Primary): ❑ Home _____ ❑ Cell _____

❑ Work _____

Reason for referral _____

_____

_____

Date of referral _____

❑ **Patient to initiate consultation**

❑ **Referring practice to initiate consultation**
Preferred Date _____
Preferred Time _____

❑ **Specialist to initiate consultation**

Please alert us if patient does not have a confirmed consultation within _____ days.

Critical patient information *(fill in lines)* _____

_____

_____

Patient payment preference:

❑ Cash/check

❑ Credit card

❑ CareCredit (card # _____)
Credit available _____

❑ Other, please specify _____

Patient previous payment history:

❑ Consistently on time

❑ A few late payments

❑ Several late payments

❑ Patient pays slow

❑ Other, please specify _____

Pre-consultation conference requested? ❑ Yes ❑ No

Specialist to provide full disclosure of all findings first to: ❑ Patient ❑ Referring doctor

Step 2: **Referral Acknowledgement** *(to be completed by specialist)*

Preferred inter-practice communication method:

- ❑ In-person
- ❑ Phone, please specify practice or cell
- ❑ Email
- ❑ Fax
- ❑ Mail
- ❑ Text message
- ❑ Other, please specify _____

Specialty practice to confirm patient consultation:

When _____ How _____

The patient will be seen by the:

- ❑ Doctor
- ❑ Treatment coordinator
- ❑ Other, please specify _____

Additional information requested:

- ❑ X-rays, digital images, please specify _____
- ❑ Labs
- ❑ Previous treatment completed
- ❑ Other, please specify _____

Step 3: **Post-Consultation Report** *(to be completed by specialist)*

Date of report: _____

Initial consultation was:

- ❑ Kept by patient
- ❑ Failed by patient
- ❑ Rescheduled to

Date _____ Time _____

Additional consultations are required:

❑ Yes ❑ No

If yes, scheduled date(s) of consultation(s)

_____

Additional specialist required:

❑ Yes ❑ No

If yes, which one(s) are recommended

_____

Summary of treatment recommended to patient:

_____

_____

_____

Treatment recommended to patient was:

- ❑ Accepted
- ❑ Delayed
- ❑ Declined
- ❑ Currently under consideration

Reason delayed/declined:

_____

_____

_____

Time-frame for follow-up:

_____

Patient payment preference for specialty care:

- ❑ Cash/check
- ❑ Credit card
- ❑ CareCredit
- ❑ Other, please specify _____

Step 4: **Post-Treatment Report** *(to be completed by specialist)*

Date of report: _____

Patient's treatment is:

- ☐ Complete
- ☐ Incomplete
- ☐ Other, please specify _____

_____

_____

If incomplete, explain

_____

_____

Post-care meeting requested with referring doctor:

☐ Yes ☐ No

Preferred date _____

Final treatment report to be provided via:

- ☐ During post-care meeting
- ☐ Mail
- ☐ Email
- ☐ Fax
- ☐ Other, please specify _____

_____

Patient to schedule post-care appointment with referring practice by:

Date _____

Special needs/considerations:

_____

_____

_____

Notes:

_____

_____

_____

_____

_____

_____

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_____