KAISER PERMANENTE®

Georgia Market

TRANSITION OF CARE REQUEST FORM

Where to send request form for OB/GYN:

OB Administrator
FAX #: 866-452-4585

Where to send request form for all other physicians:

Kaiser Permanente
Quality Resource Management
Nine Piedmont Center
3495 Piedmont Road, NE
Atlanta, GA 30305
FAX #: 866-452-4585

Member Name:_____ Medical Record:_____

Member Address: _____

_____

Member Telephone Number: _____

Date of Request: _____

Type of Request: Continue with PCP Continue with Specialist
Continue with OB/GYN 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 diagnoses. Please be specific: Attach additional sheets or submit narrative report covering all items listed below.

_____

_____

_____

_____

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 provider a complete treatment plan for the next 12 months. Include such information as surgeries planned, medications to be administered, and any protocols that will be followed.)

Treatment Plan	Medications	Protocols to be followed

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 the applicant for this condition.

Name	Address	Speciality

APPROVED: YES NO

_____ _____

Signature of Approval **Date of Approval**

Tranofca.doc:wed:4/25/00