

## Missed Appointment Follow Up

This form is to be used when your office has a patient 20 years of age and under, on Medicaid or CHP+, and would like a Family Health Coordinator to contact the family and help resolve a problem due to a missed appointment or unnecessary Emergency Department (ED) visit. We will provide your office with an update to the discussion we had with the family if we are able to reach them with the contact information you provide us.

Tri-County Health Department  
Healthy Communities **Fax: 303-745-3365**  
Healthy Communities Phone: 303-873-4404  
E-mail: **healthycommunities@tchd.org**



**Missed Appointment and Unnecessary ED Referral Sheets (1/2014)**

**Return form to:**

**Healthy Communities Outreach Team**

**Tri-County Health Department (Adams, Arapahoe, Douglas, Elbert Counties).**

**Fax: 303-745-3365**

Phone Number: 303-873-4404

*This form is utilized for missed appointments or to report an unnecessary Emergency Department (ED) visit for patients ages 0-20 years with Medicaid or CHP+.*

*Please fill out form as completely as possible. Thank you!*

**Clinic/Provider Information**

Provider Name: \_\_\_\_\_

Provider Phone Number: \_\_\_\_\_ Provider Fax: \_\_\_\_\_

Missed Appointment:  Unnecessary ED visit:  Detailed Reason for Referral \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Guardian Information**

\*Name: \_\_\_\_\_ \*Phone # \_\_\_\_\_

\*Address: \_\_\_\_\_

\*County: \_\_\_\_\_ \*Zip Code: \_\_\_\_\_ Medicaid # \_\_\_\_\_

**Childs Information**

\*Name: \_\_\_\_\_ \*Child's Date of Birth: \_\_\_\_\_

\*Child's Medicaid # \_\_\_\_\_ Family E-mail address: \_\_\_\_\_

**Family Health Coordinator Report**

Date Worked:

Action Taken: \_\_\_\_\_

Outcome of Action: \_\_\_\_\_

Date Worked:

Action Taken: \_\_\_\_\_

Outcome of Action: \_\_\_\_\_

Date Worked:

Action Taken: \_\_\_\_\_

Outcome of Action: \_\_\_\_\_

Family Health Coordinator: \_\_\_\_\_

Location: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Fax Number: 303-745-3365

Date Received: \_\_\_\_\_

Date Completed: \_\_\_\_\_

Follow-Up call to provider date: \_\_\_\_\_

Please Check Here if you would like a follow-up report after we contact (or make 3 attempts to contact) the client.