Care Transition Form

Mail to: 1244 Mariner Blvd, Spring Hill, FL 34609
Or Fax to: (352) 515-5975

Member Information

Member Last Name: ________________________ Member First Name: ________________________

Date of Birth: ______________________________ Preferred Phone #: __________________________

Transition Information

Do you have any of the following illnesses?

- ☐ Asthma
- ☐ Cancer
- ☐ High Cholesterol
- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Kidney/Liver Problems
- ☐ Mental Health Issues
- ☐ HIV
- ☐ Developmental Disabilities

Are you receiving any of the following services? ☐ YES ☐ NO

Service	Company/Provider	Provider Phone Number
Oxygen		
Medical Equipment		
Other Equipment		
Rehab/Physical Therapy		
Home Health		
IV Medication / Chemotherapy		
Radiation Therapy		

Do you have any Hospitalizations, Surgeries or Procedures Scheduled? ☐ YES ☐ NO

Date	Type of Surgery/Procedure	Provider Name and Phone Number	Hospital/Facility

Have you had a transplant in the last year? ☐ YES ☐ NO

If Yes what kind? ____

Have you been admitted to the hospital in the last 6 months? ☐ YES ☐ NO

Have you been to the Emergency Room in the last 6 months? ☐ YES ☐ NO

Other Needs/Comments: (List what kind of medical Equipment – hospital bed, electric wheelchair, etc.)

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