Catholic Medical Partners Hospitalist Referral Agreement

This agreement outlines the referral agreement between __________________________and __________________________ for formal consultation and co-management of patients admitted to an acute care facility in which the Hospitalist practices. The purpose of this agreement is to provide a framework for better communication, coordination of care and the safe transition of care between primary care and Hospitalist to eliminate waste and excess costs of health care, as well as optimizing patient health.

The Primary Care Provider (PCP) and the Hospitalist (HOSP) agree to collaborate in the care and treatment of patients as set forth below:

- The PCP agrees to share clinical information including diagnosis (problem list), pertinent diagnostic test results, medication list, allergy list and HPI if known when sending a patient to the hospital or when notified by HOSP that the patient has been admitted.
- The HOSP agrees to care for patient and to notify the primary care physician in conjunction with hospital and Care Management Team of admissions, transfers and discharges related to patients referred to HOSP within 24 hours.
- The HOSP agrees to send all new clinical information back to the PCP along with care recommendations within 24 hours of discharge.
- Please note the agreed upon preferred form of communication:
  - Electronic transfer (CCD or access to EHR)
  - Fax
  - Telephone call
  - Other (please specify) _________________________________________
- Other specific aspects of agreement:

___________________________________________________________________________________
___________________________________________________________________________________
___________________________________________________________________________________
___________________________________________________

This agreement outlines expectations between the PCP and the HOSP. It does not, in any way, limit the patient’s freedom to select his/her physician of choice or make a self-referral to a provider of the patient’s selection.

☐ I, (print your name or group here)________________________, do not refer to hospitalists for inpatient care and follow my own hospitalized patients.

Primary Care Physician/Practice
Authorized Name: ____________________  Title: ____________________
Signature: ___________________________  Date:______________________

Hospitalist Physician/Practice
Authorized Name: ____________________  Title: ____________________
Signature: ___________________________  Date:______________________