Revised 3/28/2022

Johns Hopkins Post-Acute COVID -19 Team (JH PACT)
Phone- 443-287-2616
Fax- 410-367-2725
Email- PACT @jhmi.edu

Ambulatory Referral to JH PACT

******Patient must have had COVID to enroll******

Patient Name: _____ DOB: _____ Phone: _____

Johns Hopkins medical record number (if known): _____

Home Address: _____

Check applicable option(s) below:

- ☐ COVID-19 related hospital admission
- ☐ COVID-19 related ongoing pulmonary symptoms/abnormalities
- ☐ COVID-19 related ongoing neuropsychological/physical symptoms

When was the patient diagnosed with COVID-19 (If multiple infections please provide all dates):

If the patient was hospitalized for COVID-19 provide hospital name/location:

- Did the patient require HFNC? Y/N Intubation? Y/N

Is the patient currently on home Oxygen Y/N:

- Is the oxygen new Y/N
- _____ LPM

Please check all applicable symptoms the patient is experiencing:

- ☐ Fatigue
- ☐ Cough
- ☐ Cognitive Impairment
- ☐ Chest Pain
- ☐ Dysautonomia/POTS
- ☐ Shortness of Breath
- ☐ Brain Fog
- ☐ Headache
- ☐ Neuropathic Pain
- ☐ Other – Please Explain:

Provider Name: _____

Phone: _____ Fax: _____

Provider Signature(stamp or e-sign acceptable): _____ Date: _____

If patient was not seen at a Hopkins facility, please send

- ☐ Documentation of a positive COVID-19 test or summary of clinical diagnosis of COVID-19 without positive test
- ☐ Discharge summary for any COVID related hospital admissions
- ☐ Most recent clinic notes related to COVID-19 or long COVID

If applicable to the patient OR already completed please send

- ☐ Chest X- ray and or Chest CT results
- ☐ Echo Results
- ☐ Pulmonary function tests
- ☐ Physical Therapy, Speech Therapy and/or Occupational Therapy notes

IF THIS FORM IS NOT FULLY COMPLETED, THE PATIENT WILL NOT BE SCHEDULED.
If you have further questions please contact PACT@jhmi.edu
Due to the volume of referrals please note we are scheduling new patients 2-3 months out. Please note we are a referral center and cannot accomodate urgent appointments.

To check list of accepted insurance plans visit:
https://intranet.insidehopkinsmedicine.org/managed-care/payor-directory.html

Maryland Uniform Consultation Referral Form

Date of Referral:	**Carrier Information:**
Patient Information:	Name:
Name: (Last, First, MI)	Address:
Date of Birth: (MM/DD/YY) / Phone: ( )	Phone Number: ( )
Member #:	Facsimile/Data #: ( )
Site #:	

Primary or Requesting Provider:

Name: (Last, First, MI)		Specialty:
Institution/Group Name:	Provider ID #: 1	Provider ID #: 2 (If Required)
Address: (Street #, City, State, Zip)		
Phone Number: ( )	Facsimile/Data Number: ( )	

Consultant/Facility Provider:

Name: (Last, First, MI)		Specialty:
Institution/Group Name:	Provider ID #: 1	Provider ID #: 2 (If Required)
Address: (Street #, City, State, Zip)		
Phone Number: ( )	Facsimile/Data Number: ( )	

Referral Information:

Reason for Referral:

Brief History, Diagnosis, and Test Results: *(Include ICD-9)*

Services Desired: Provide Care as indicated:	**Place of Service:**
☐ Initial Consultation Only:	☐ Office
☐ Diagnostic Test: (specify) _____	☐ Outpatient Medical/Surgical Center *
☐ Consultation With Specific Procedures: (specify) _____	☐ Radiology ☐ Laboratory
_____	☐ Inpatient Hospital *
☐ Specific Treatment: _____	☐ Extended Care Facility *
☐ Global OB Care & Delivery	☐ Other: (Explain)
☐ Other: (Explain)	* (Specific Facility Must be Named.)

Number of Visits: _____ . If Blank, 1 Visit is Assumed.	**Authorization #:** (If Required)	Referral is Valid Until: (Date) _____ . (See Carrier Instructions)

Signature: (Individual Completing This Form)	**Authorizing Signature:** (If Required)

Referral certification is not a guarantee of payment. Payment of benefits is subject to a member's eligibility on the date that the service is rendered and to any other contractual provisions of the plan / carrier.

White: Carrier; Yellow: Primary or Requesting Provider; Pink: Consultant/Facility Provider; Goldenrod: Patient

See Carrier/Plan Manual for Specific Instructions.