Kentucky Homeplace Referral

(To be completed by the referring provider)

Patient's name: ___________________________________ Date of Birth: ____/____/______
Patient phone number_______________________________ County of Residence:________________________
Referral Source: Hospital FQHC Office
P Physician NP PA Dentist
Most Recent Lab Results AIC______Cholesterol_______Random Glucose_______

Refer for Care Coordination: (Check all that apply)

- ❑ Diabetes
- ❑ Hypertension
- ❑ Heart Disease (at risk for Heart Disease)
- ❑ COPD
- ❑ Management of Health Risk Factors
- ❑ Preventative Screenings
- ❑ Obesity
- ❑ Prevention (Pre-diabetes Education)
- ❑ Behavioral Change___________ (Smoking Cessation, Physical Activity, Healthy Diet)
- ❑ Medication Access
- ❑ Hearing (hearing aids reduced rates)
- ❑ Vision needs (eyeglasses)
- ❑ Medical assistive devices
- ❑ Enroll/Re-enroll Medicaid & KCHIP
- ❑ **Chronic Disease Self-Management Program** (6 weeks at 2.5 hours per week)
- ❑ **Diabetes Self-Management Program** (6 weeks at 2.5 hours per week)
- ❑ **The Arthritis Foundation Walk With Ease Program** (Individual or Group Led)

Referral Provider Note:

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NURSE/DCP/CM: _________________________ Contact info: _________________________

Provider Signature: _________________________ Date of Referral: _____________________

CHW Signature: ___________________________

Email: KentuckyHomeplace@uky.edu

Phone: 606-439-3557 ext. 83449

Fax: 606-438-0638

Address: 750 Morton Blvd.
Hazard, KY, 41701

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