Attachment A

PRIMARY CARE LINKAGE REFERRAL FORM

Please provide patient status and return completed form at **ReturnLinkageForms@dhs.lacounty.gov by XX/XX/XX**

COMMUNITY PARTNER:		SITE:	

PATIENT INFORMATION							CONTACT OUTCOME STATUS: Check (✓) Each Attempt Made (A) and Indicate Final Outcome (B)						
							A) CONTACT ATTEMPTS			B) CONTACT OUTCOME			
#	FIRST NAME	LAST NAME	MRUN	D.O.B.	MHLA Application ID	Date MHLA Application was Started by DHS (CP has 30 Days to Complete the Patient Enrollment)	ATTEMPT #1	ATTEMPT #2	ATTEMPT #3	UNABLE TO CONTACT	PATIENT DECLINED	*My Health LA* SCHEDULED ENROLLMENT DATE	ADDITIONAL COMMENTS
1							☐	☐	☐	☐	☐		
2							☐	☐	☐	☐	☐		
3							☐	☐	☐	☐	☐		
4							☐	☐	☐	☐	☐		
5							☐	☐	☐	☐	☐		
6							☐	☐	☐	☐	☐		
7							☐	☐	☐	☐	☐		
8							☐	☐	☐	☐	☐		
9							☐	☐	☐	☐	☐		
10							☐	☐	☐	☐	☐		
11							☐	☐	☐	☐	☐		
12							☐	☐	☐	☐	☐		
13							☐	☐	☐	☐	☐		
14							☐	☐	☐	☐	☐		
15							☐	☐	☐	☐	☐		
16							☐	☐	☐	☐	☐		
17							☐	☐	☐	☐	☐		
18							☐	☐	☐	☐	☐		
19							☐	☐	☐	☐	☐		
20							☐	☐	☐	☐	☐		

DATE SENT: X/XX/2018

ATTN: DHS LINKAGE COORDINATOR - Please provide patient status and return completed form at ReturnLinkageForms@dhs.lacounty.gov by: XX/XX/XX