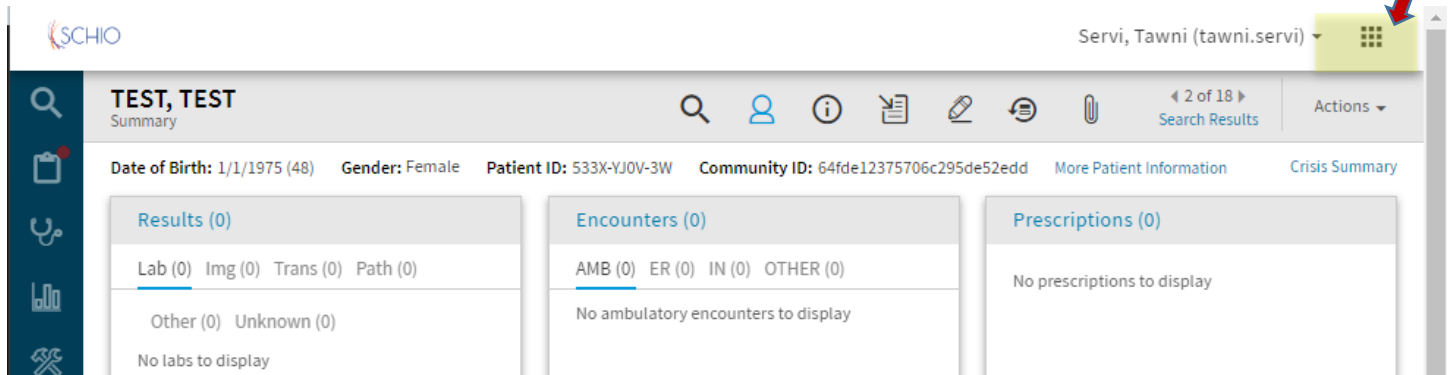


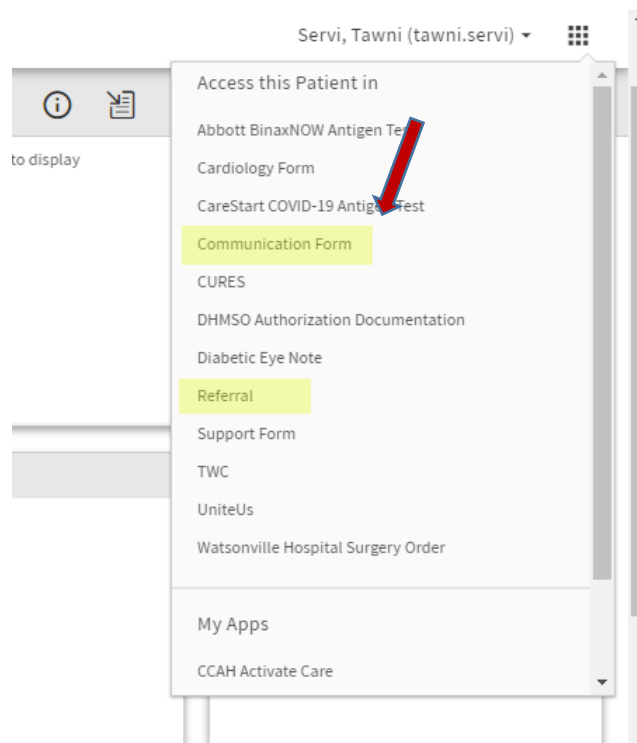


CREATING HIE FORMS – Referral, Communication and Order

In a patient chart, click the square on the top right corner of the screen



Choose the required form in the top section



Sample Communication Form

Communication Form
✓

Last Name	First Name	Date of Birth	Gender
TEST PATIENT	TEST	1975/10/23	Male
Address	City, State, Zip	Phone	Alternate Phone
3700 CRACKLE OAK AVE BUILDING 8 UNIT 5	WINTER SPRINGS, FL, 32708	4077447700	

* ORDERING PHYSICIAN:

Copy to Provider:

Enter at least the first two characters of the provider's last name.

Communication Form

Document

Cancel
Sign/Send

Sample Referral Form

Last Name	First Name	Date of Birth	Gender
TEST PATIENT	TEST	1975/10/23	Male
Address	City, State, Zip	Phone	Alternate Phone
3700 CRACKLE OAK AVE BUILDING 8 UNIT 5	WINTER SPRINGS, FL, 32708	4077447700	

* Primary Insurance Company	* Policy Number	* Group Number	* Subscriber Name
<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>
Verify or enter insurance company name	Verify or enter insurance policy #	Verify or enter insurance group #	Verify or enter subscriber name

* Referred FROM Provider:	* Referred TO Provider:	Primary Care Provider:
<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>
	Required: enter at least the first two characters of the provider's last name.	Enter at least the first two characters of the provider's last name.

Initial Request Date	Number of Visits	* Urgency	* Authorization Required?
<input style="width: 95%;" type="text" value="6/26/2020"/>	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text" value="Please select:"/>	<input type="radio"/> Yes <input type="radio"/> No

* Diagnosis	Additional Diagnosis	Additional Diagnosis
<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>
Required: enter at least the first two characters of the ICD10 code or description.		
Additional Diagnosis	Additional Diagnosis	Additional Diagnosis
<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>

Relevant clinical data in the SCHIE.
 I am sending supporting documents via Direct Messaging.
 I am faxing supporting documents.

* Reason for Referral/Notes

Cancel
Sign/Send