Care Transition Form

INSTRUCTIONS: If you answer (**YES**) to any of the questions below, please complete and return this form.

- By Mail to: PO Box 3459, Spring Hill, FL 34611
- Or Fax: 352-515-5975
- Or E-Mail: UHPUM@ulthp.com

Member Information

LAST NAME	FIRST NAME
BIRTHDATE (MM/DD/YYYY)	PREFERRED PHONE NUMBER

Transition Information

1. **Do you have any of the following illnesses?**

☐ COPD/Asthma ☐ Active Cancer Treatments ☐ DVT/Pulmonary Embolism
☐ Diabetes ☐ Coronary Artery Disease/CAD ☐ Kidney/Liver Problems
☐ Heart Failure ☐ Peripheral Vascular Disease/PVD ☐ Upcoming Transplants

2. **Are you receiving any of the following services?** ☐ Yes ☐ No

Service	Company/Provider	Provider Phone Number
Oxygen		
Medical Equipment		
Other Equipment		
Rehab/Physical Therapy		
Home Health		
IV Medication/Chemotherapy		
Radiation Therapy		

3. **Do you have any Hospitalizations, Surgeries, or Procedures Scheduled?** ☐ Yes ☐ No

Date	Type of Surgery/Procedure	Provider Name and Phone Number	Hospital/Facility

4. **Have you had a transplant in the last year?** ☐ Yes ☐ No
   a. If yes, what kind?

5. **Have you been admitted to the hospital in the last 6 months?** ☐ Yes ☐ No
6. **Have you been to the Emergency Room in the last 6 months?** ☐ Yes ☐ No
7. **Other Needs/Comments:** (List what kind of medical equipment – hospital bed, electric wheelchair, etc.)

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