TEXAS HEALTH STEPS
PROVIDER OUTREACH REFERRAL FORM
FAX: 512-533-3867

- **Complete this form and submit by fax.**
- **Use only ONE FORM PER HOUSEHOLD, up to 2 patients.**
- **You will receive notification once your referral is processed.**

Provider Information

Date:

Provider/Clinic Name:		Contact Name:	
Office Address:	City:	County:	Zip Code:
Phone Number:		Fax Number:	
Provider Type: ☐ Medical	☐ Dental	☐ Orthodontic	☐ Case Management ☐ Other:

Parent/Guardian Information

Parent/Guardian Name:	Phone Number:	Mobile Number:	
Address:	City:	County:	Zip Code:
Language Preference: ☐ English	☐ Spanish	☐ Other:	

Patient #1 Information

Patient Name:	Date of Birth:	Medicaid ID:		
Appointment Type: ☐ THSteps Checkup	☐ THSteps Followup	☐ Sick Visit	☐ Lead	
☐ Other:				

Reason for referral (*check all that apply*)

☐ Patient missed appointment, date:	☐ Assistance needed scheduling appointment.
☐ Follow-up appointment for additional lead testing.	☐ Provide updated patient address (*Case Management Only*)
☐ Assist with transportation to appointment.	☐ Other, see comments.

Comments:

Outreach Services Results (*SSU Use Only*)

☐ Appointment scheduled; date/time:	☐ Patient provided education about appointment etiquette.
☐ Patient assisted with transportation to appointment.	☐ Patient will contact provider directly.
☐ No action taken; patient declined assistance.	☐ No action taken; patient no longer eligible for Medicaid.
☐ Unable to locate patient; letter mailed to patient.	☐ Other:

Comments to Provider:

Patient #2 Information

Patient Name:	Date of Birth:	Medicaid ID:		
Appointment Type: ☐ THSteps Checkup	☐ THSteps Followup	☐ Sick Visit	☐ Lead	
☐ Other:				

Reason for referral (*check all that apply*)

☐ Patient missed appointment, date:	☐ Assistance needed scheduling appointment.
☐ Follow-up appointment for additional lead testing.	☐ Provide updated patient address (*Case Management Only*)
☐ Assist with transportation to appointment.	☐ Other, see comments.

Comments:

Outreach Services Results (*SSU Use Only*)

☐ Appointment scheduled; date/time:	☐ Patient provided education about appointment etiquette.
☐ Patient assisted with transportation to appointment.	☐ Patient will contact provider directly.
☐ No action taken; patient declined assistance.	☐ No action taken; patient no longer eligible for Medicaid.
☐ Unable to locate patient; letter mailed to patient.	☐ Other:

Comments to Provider:

TEXAS HEALTH STEPS
PROVIDER OUTREACH REFERRAL SERVICES

FAX COVER SHEET

DATE: _____

TO: SPECIAL SERVICES UNIT

PHONE: 877-847-8377

FAX: 512-533-3867

FROM: _____

PHONE: _____

FAX: _____

TOTAL PAGES INCLUDING COVER SHEET: _____

COMMENTS:

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