



*Compassionate Collaborative Care*

6101 Frisco Square Boulevard  
2<sup>nd</sup> Floor  
Frisco, TX 75034  
Phone: (469) 365-0772  
Fax: (888) 977-6892  
www.PACollin.org

## New Patient Enrollment Request Form

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Patient Name	Age	Date of Birth	Sex	M	F
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Home Phone #	Work Phone #	Other Phone #
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Street Address	Apt #	City	ZIP
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Level of Urgency:  0-2 weeks  2-4 weeks  When possible  As directed \_\_\_\_\_

**Physician requesting patient referral:**

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Print Name (Physician must be a participating PACC volunteer)	Specialty
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Address	City	ZIP
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Contact Person	Phone	Fax
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**Reason for Referral (please PRINT):**

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Once PACC receives this form and the patient has been screened for eligibility, you will be notified. If you are the patient's PCP, the patient will remain in your medical practice, where you will continue to serve as the patient's medical home.

**Please Fax this form to PACC at (888) 977-6892      Questions? Call PACC at (469) 365-0772**

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