Project Access Collin County
Compassionate Collaborative Care
8680 E. Main Street, Suite 3E
Frisco, TX 75033
Phone: (469) 365-0772
Fax: (888) 977-6892
www.PACollin.org

PACC Referral Request Form

PART A: PHYSICIAN REQUESTING REFERRAL

Physician: _____ Specialty: _____

Address: _____

Contact Person: _____ Email: _____

Office Phone #: _____ Office Fax #: _____

PART B: PATIENT DEMOGRAPHICS

Name: _____ PACC ID #: _____

□ Male □ Female Age: _____ Date of Birth: _____

Address: _____ Apt: _____ City: _____ Zip: _____

Phone #:_____ Work #: _____ Other #: _____

PART C: SPECIALIST REQUIRED

Level of Urgency: □ 0-2 weeks □ 2-4 weeks □ When possible □ As directed _____

Specialist Requested: _____

Please provide most recent H&P, lab report, and relevant diagnostic reports that applies to this visit.

PART D: DIAGNOSTIC PROCEDURE REQUESTED

Level of Urgency: □ 0-2 weeks □ 2-4 weeks □ When possible □ As directed _____

Diagnosis: _____

ICD-10 Code(s): _____

CPT Code(s): _____

Date of Surgery (if applicable): _____ Time of Surgery (if applicable): _____

Facility: _____ Surgeon: _____ Anesthesia: □ yes □ no

Procedure(s): _____

Procedure Length: _____ Special Needs/Requests: _____

PHYSICIAN SIGNATURE _____ Date _____

Please note: PACC patients can be referred to current physician volunteers only. Only medically necessary care will be provided through the PACC program, unless the resource is available. Elective procedures are not covered. For more information, please visit PACollin.org or call 469-365-0772.