CAROLINA FAMILY HEALTH CENTERS, INC.

REQUEST TO TRANSFER CARE

Date:_____ Present Provider:_____

Patient Name:_____ Patient Signature:_____

Date of Birth:_____ Telephone Number:_____

Please check all that apply:

Internal/External Transfer (choose one)

- ☐ I request a change in my medical/dental/behavioral health provider (internal transfer).
- ☐ I am transferring care to another provider in the service area (Nash, Edgecombe, or Wilson County)
- ☐ I am transferring outside of service area (Nash, Edgecombe, or Wilson County)

Please indicate the reason for your request to transfer your provider below.

Waiting

- ☐ It takes too long to get an appointment.
- ☐ I have to wait in the lobby for too long.
- ☐ I have to wait in the exam room for too long.
- ☐ I do not get a prompt reply when I leave a phone message.

Patient/Provider Relationship

- ☐ I do not think my provider listens to me.
- ☐ My provider does not spend enough time with me.
- ☐ My provider does not explain things to me very well.
- ☐ My provider does not know about my health history.
- ☐ I do not get the results of my tests.

Preferences

- ☐ I prefer an MD instead of a PA or FNP.
- ☐ I am requesting a change because of gender preference.
  - ☐ I prefer a Male
  - ☐ I prefer Female
- ☐ I do not like the nurse that works with my provider.
- ☐ I do not like the interpreter that works with my provider.
- ☐ I need to transfer to another location because of where I live.

Care and Treatment

- ☐ I needed a referral, and my provider would not agree.

Other:_____

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