American Board of Oral and Maxillofacial Surgery

# Annual Patient Continuity of Care Plan

You may fax this form to (312) 642-8584 or email to: Ms. Raquel Kalfus at RKalfus@aboms.org.

**ABOMS Diplomates without hospital privileges must submit this Continuity of Care Agreement either between another ABOMS Diplomate with hospital privileges, or a Hospital to assure continuity of care when a patient requires hospital care for oral and maxillofacial care.**

## Accepting Diplomate Information

First Name: _____ ABOMS Diplomate Number: _____

Middle Name: _____

Last Name: _____

**OR**

## Hospital

Name: _____

City: _____ State: _____

**NOTE: Referral to a hospital emergency department is <u>not</u> an acceptable Plan of Tranfer.**

_____ _____

**Referring Diplomate Signature** **Accepting Diplomate Signature**

Date: _____ Date: _____

**OR**

_____ _____

**Hospital Medical Staff Representative Name** **Hospital Medical Staff Representative Signature**

Date: _____