University of Colorado at Boulder
Wardenburg Health Services
Medical Clinic
Chronic Care Team
1900 Wardenburg Dr.
Boulder, Colorado 80309-0119
Phone: 303-492-5432/ RN line: 303-492-3435
Fax:303-492-4875

Chronic Care Team

Memorandum of Understanding (MOU)

Dear Student:

Welcome to the Chronic Care Team (CCT)! Our team is made up of medical providers, nurses, behavioral health providers, and most importantly, YOU. We are dedicated to working with you and your specialist(s) to ensure continuity of care for the management of your chronic medical condition while you are a student at CU Boulder.

For many of you, this will be the first time you are taking a more active role in managing your condition. You may ask "What does managing my own health look like?". A few examples are scheduling your own appointments, ordering your specialty medications, self-administering medications, following up on lab results, etc. As a team, we are committed to empowering and educating you on how to take the lead in managing your own health.

We are excited for you to begin this next chapter in your life. Please sign below that you are committed to being an active member of the Chronic Care Team.

Name: _____ Date of Birth: _____

Signature: _____ Date: _____

***Please fax MOU to our ROI office at 303-492-4875**

Chronic Care Team

Getting Started: A step by step guide

1. Contact your specialist's office and have them complete and fax forms to our Release of Information (ROI) office at 303-492-4875. If you have more than one specialist, please have each specialist complete.

    a. *Special Information* (Attachment A)

    b. *Medication Order* (Attachment B)

2. Sign a Release of Information (ROI) Form allowing us to discuss your care with your specialist(s).

    a. Log into your patient portal at www.mycuhealth.colorado.edu, using the same user name and password you use to register for classes. Under the Forms Icon, select General Authorization to Release Health Info. If you do not have access to your patient portal, call the ROI office at 303-735-2068.

    b. If you want us to be able to discuss your care with your parent(s), you must fill out a separate ROI for them, following the same process outlined above.

3. Schedule an initial 30-minute Meet & Greet appointment with the CCT by calling our Schedulers at 303-492-5432. Please note that our schedulers will ensure that you have completed step 1 and 2 prior to scheduling. Meet and Greets can be scheduled prior to the start of the academic year. They are a great way to discuss your medical condition and how we can support you during your time at CU Boulder.

4. Contact your Specialty Pharmacy and notify them that you will be changing your Medication Delivery Address to:

    University of Colorado at Boulder
    Wardenburg Health Services
    Medical Clinic Attn: CCT Nurses
    1900 Wardenburg Dr.
    Boulder, Colorado 80309-0119
    *Shipping Hours Monday-Friday 8am-4pm, Closed Weekends and Holidays

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Specialist's Information
(To be completed by specialist office)

Patient Name: _____

Date of Birth (DOB): _____

The above listed patient will be, or is currently, a student at the University of Colorado at Boulder and has requested that the Chronic Care Team (CCT) participates in the continuity of their care for their chronic medical condition while they are a student at CU. The CCT is a nurse lead team that works in conjunction with MDs, NPs, Behavior Health Specialists, and most importantly, the patient. That being said, we as a team will defer to you, the specialist, for the primary management of the patient's condition including medication orders and adjustments and monitoring of labs. **Please complete the following form(s) and send all applicable information to WHS's Release of Information (ROI) office at 303-492-4875.**

1. Specialist's Information
    a. Provider's Name: _____
    b. Practice Name: _____
    c. Phone: _____
    d. Fax: _____

2. Brief History of Chronic Illness including
    a. Condition:_____
    b. Year diagnosed:_____
    c. Date of last visit: _____

Specialist's Information (continued)
(To be completed by specialist's office)

3. Copy of last medical evaluation pertaining to chronic condition from your office including:
    a. Up to date medication list with frequency and dosage
    b. Pertinent labs
    c. Pertinent studies (i.e. radiology, colonoscopy, endoscopy, EKG, etc…)

4. If you would like us order labs and send results to you, please include the following:
    a. Lab order: _____
    b. Frequency: _____
    c. Where to send results if different from phone and fax listed above
        i. Phone: _____
        ii. Fax: _____

5. Medication Order if applicable (See Attachment B). Please note, no IV infusion medications can be administered at WHS.

Physician/ Medical Provider's Signature: _____Date:_____

***Please fax completed forms to our ROI office at 303-492-4875**

Attachment B

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Medication Order

(if requesting medication administration at WHS).

Patient Name: _____

Patient DOB: _____

Medication: _____

Dose: _____

Route: _____

Frequency: _____

Order Start Date: _____

Order Expiration Date: _____

Physician/ Medical Provider's Signature: _____Date:_____

***Please fax order to our ROI office at 303-492-4875. Please note that IV infusion medications cannot be administered at WHS.**

Chronic Care Team: Useful Information

Website:

colorado.edu/healthcenter/services/primary-care/chronic-care-team

Insurance Options:

Colorado.edu/health/insurance-options

*All visits are covered by student health insurance plan Gold SHIP. If you elect to use your own private insurance, we can bill them directly (Current contracted insurance: Tricare, Anthem, Cigna, United) Simply provide us with your insurance card when you check in for your appointment. The BuffCare Supplement can help cover any out-of-pocket expenses after the insurance has been billed.

Address:

University of Colorado at Boulder
Wardenburg Health Services
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1900 Wardenburg Dr.
Boulder, Colorado 80309-0119

Hours of Operation:

Monday- Friday 8am-4pm, Closed weekends and Holidays

Helpful contact info

Schedulers: 303-492-5432
Main Line: 303-492-5101
CCT RNs: 303-492-3435
Release of Information office (ROI): ph 303-735-2068 fax 303-492-4875
Apothecary Pharmacy: 303-492-8553
Billing: 303-735-4001, Colorado.edu/healthcenter/private-insurance-billing
Referral Coordinator: Andi Wittenberg andrea.wittenberg@colorado.edu
CAPS: 303-492-2277, colorado.edu/counseling
Disability Services: 303-492-8671, Colorado.edu/disabilityservices
Students Support and Case Management: 303-492-7348, sscm@colorado.edu, Colorado.edu/sscm

Health and Wellness Services
UNIVERSITY OF COLORADO **BOULDER**

Request for Prescription Medication Delivery and Waiver

Name: _____

Address: _____

Phone number: _____

Date of birth: _____

Name of prescription to be delivered: _____

Name of delivering pharmacy: _____

Pharmacy address: _____

Pharmacy phone number: _____

I authorize the University of Colorado Boulder Medical Services to receive and store my prescription delivery from the above listed pharmacy.

I understand that:

- I must complete and sign this Waiver and Release form prior to sending any medication to Medical Services.
- The pharmacy must only deliver prescriptions Monday through Friday between 8:30-4:30 pm, excluding University holidays.
- The University of Colorado Health and Wellness Services staff cannot determine whether products were stored properly while in transit, are out-of-date, or were repackaged prior to arriving at our facility.
- I am responsible for tracking and maintaining an adequate stock of medication.
- If I do not pick up the medication and it expires, it will be discarded.

I understand that Medical Services is agreeing to receive and store my prescription delivery as a courtesy to its students. This agreement may be revoked at any time by written notice. Medical Services does not guarantee the security of the property being stored. I am responsible for ensuring that the prescription is delivered within the parameters listed above. I release and waive the Regents of the University of Colorado, a body corporate, and its member officers, agents, employees, and any other persons or entities acting on their behalf, and the successors and assigns from all claims, damages, or loss arising from the delivery or storage of the medication listed above.

I hereby certify that I have read and understand the provisions of this agreement. For participants under 18 years of age, the parent or guardian accepts the above terms.

Signature: _____ Date:_____

Parent/Guardian Signature for Minor: _____ Date:_____