

CARE COORDINATION REFERRAL FORM

PHONE 877-252-6002 | FAX 405-213-1145

Referral by:	by: Phone:		Referral date:		
		<u>.</u>			•
	REF	ERRAL SOURCE			
Primary Care Provider	Emergency Department		Community Agency		
Specialty Provider	Caseworker/DC Planner		Tran	sition Coordinator	
Other:					
	Men	nber Information:			
equired information* If the	information	on is not available,	please	ехр	lain in the box below
		T		Т	
Member Name:	*Member ID:				
Member DOB:	*Member Phone:				
Contact Name:	*Contact Phone:				
Relationship to Member:	er: Language Preferer		nce:		
	DEAS	ON FOR REFERRAL			
Assistance with Out of					Social Services
State Needs:	Complex Care Management Needs including but not limited to:			Coordination:	
At risk newborn or child	Chronic Health issues			Meals	
with special needs	Diabetes			Lodging	
Medication review	High Blood Pressure			Assistance with	
needed	Heart Disease			transportation	
High emergency	Arthritis			Community	
department utilization	Sickle Cell Disease			Resources	
Other:					
LEASE DESCRIBE CONCER	NS, REASO	NS FOR REFERRAL	, AND	ATT.	ACH RELEVANT
EDICAL RECORDS. ATTAC	HING RELE	VANT MEDICAL RE	CORDS	S WI	LL EXPEDITE CARE
OORDINATION PROCESS.					



