[HEALTH CENTER LOGO]

**Care Management Referral**

[HEALTH CENTER NAME] offers care management services to high-risk patients with multiple chronic conditions, behavioral health concerns, and socioeconomic barriers. Care management services provide one-on-one support to assist individuals, and their provider and care team, to manage their conditions and followed a prescribed plan of care.

To best support our providers and patients, [HEALTH CENTER NAME] has instituted a Care Management Referral Form that providers can complete (via hard copy or electronically) when it has been determined that a patient may benefit from the care management services we offer. Providers are requested to discuss the referral with their patients in order to support engagement and avoid patient confusion.

***Care Manager Contact Information:***

Name:

Location: (e.g., site name, office #)

Phone:

Email:

**Indicators for referral to High-Risk Care Management:**

* Multiple chronic conditions (typically 4-5 but can differ depending on patient circumstances)
* Specific chronic conditions including heart disease, HTN, COPD, cancer, asthma, diabetes, obesity, and depression.
* Social risks (e.g., housing instability, food insecurity, transportation issues, unable to afford medications)
* Mental health conditions
* Provider or care team knowledge that patient is at risk with managing current health conditions

**Care Management Services that are provided to patients:**

* **Dedicated Care Manager** to assist patients in managing their health and prescribed care plan.
* **Comprehensive care plan** that reflects action steps and goals set in collaboration with the patient.
* **Regular check-ins** (typically monthly) via phone or visits to assist patients in staying on track.
* **Communication support** between patient and care team.
* **Linkage** to community resources and support, as needed.
* **Appointment compliance** through reminders and other supports.
* **Care transition** support, including follow-up after hospital discharge or emergency room visits.
* **Medication management** including support obtaining and reconciling medications.
* **Referral completion** by helping patients remember and get to referral appointments.

Forward Care Management Referral to [CARE MANAGER NAME] via FAX: (xxx) or EMAIL to (xxx)

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| Date of Referral: |
| Referring Provider or Care Team Member: |
| Referring Provider/Care Team Member  | Phone: | Email: |
| **Patient Information:** |
| Patient Name (First, M.I., Last): |
|  | Patient ID: | Patient DOB: |
| Patient Phone (home): | Patient Phone (cell): |
| **Provider Information:** |
| PCP Name: |
|  | PCP Phone: | PCP Email: |
| **Reason for Referral:** |
| **Patient’s social risks** (circle all that apply): \_\_\_\_\_ Housing instability \_\_\_\_\_Transportation issues \_\_\_\_\_ Food insecurity \_\_\_\_\_ Unable to afford medications \_\_\_\_\_ Other (describe): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Patient’s chronic conditions:** \_\_\_\_\_ Heart disease \_\_\_\_\_ Asthma \_\_\_\_\_ Other (describe): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_ HTN \_\_\_\_\_ Diabetes \_\_\_\_\_ COPD \_\_\_\_\_ Obesity  \_\_\_\_\_ Cancer \_\_\_\_\_ Depression**Additional information regarding referral:** |
| Referral has been discussed with patient (check one): Yes \_\_\_\_ No \_\_\_\_\_ If yes, referral was discussed by (Name):  |
| **For Internal Care Manager:** Referral Review Date:Care Management Action (check one): Proceed with enrollment \_\_\_\_ Follow-up with Provider or Referral Source \_\_\_\_\_Date Referral Source Notified of Referral Outcome:Date Patient Contacted via Referral: |