HealthChoice
Delivering Healthcare Solutions.

Care Management Referral

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Please complete this form and FAX or EMAIL to the number(s) listed in the upper right hand corner of this page. Once you have sent the form, *please call the number listed above to confirm receipt.*

Referring Provider:

______________________	______________________	______________________	_________________________
Last Name/Title (print)	First Name	Phone	E-Mail Address

Member Information:

____________________	____________________	_______	(_______)____________________
Last Name	First Name	MI	Phone

DOB: ____/____/____ Ins. Carrier: __________________________ Member ID: _________________

Policy #: ____________________ Insured Employer Name: ____

Secondary Insurer: ____________________________________

Brief History and Reason for Referral:

☐ **Documents attached:**

Care Management Services Requested:

☐ **Complex Care Management** –For patients with complex conditions. Services include home visit and assessment with telephone follow-up- Care plan development- Disease process education- Medication review-Self-care management- Care coordination with providers

☐ **Care Transition**- For those with an inpatient stay or frequent ED visits. Telephonic follow-up post discharge - Education on appropriate use of services , discharge instruction, disease process and red flag - Medication review - Assistance with appointment scheduling - Sharing discharge summary information

☐ **Diabetes Prevention –** For those with Pre-Diabetes. Based on the 12 month National Diabetes Prevention lifestyle change program. 16 weekly one-hour core sessions followed by 6 monthly sessions. Working with a lifestyle coach and other professionals to reduce the risk of developing diabetes.

Has member agreed to this referral? ☐ Yes ☐ No **Date Consented**: __________________

What is the projected goal for the patient? ____

Past Medical History:

☐ Blood Clots	☐ Heart Disease	☐ Lung Disease	☐ Other:___________________
☐ Cancer	☐ High Blood Pressure	☐ Seizures/Epilepsy	_________________________
☐ Depression	☐ High Cholesterol	☐ Stroke	_________________________
☐ Diabetes	☐ Kidney Disease	☐ Transplant	_________________________

Person Completing Form:

______________________	______________________	______________________	____/____/____
Last Name (print)	First Name	Phone	Date

Thank you for your referral to HealthChoice, Care Management Services. Our staff will review your request, contact the member and complete an Intake form to determine need. A referral to the appropriate program will occur once this is complete. We will notify you of the disposition of this referral within two weeks.