Care Management Referral Form

Date: _____

Completed by: _____

Patient Name: _____

Patient DOB: _____

Patient's Address: _____

_____

Patient's Phone Number: _____

Caregiver contact information (name and number, if applicable):

_____

Reason for referral to Care Management:

_____

Exclusion criteria: Patient is on hospice; patient resides in a Long-Term Care facility.

Care Management program for referral:

- o Complex Care Management (RN's)
- o Conditional Management (Health Coaches)
- o Social Work Care Management
- o Behavioral Health Care Management

Additional Comments:

Email completed form to: caremanagement@promisehealthplan.com along with any clinic notes relevant to need for care management.