Community Care
OF NORTH CAROLINA

Adult Care Management Referral Form

Date: _____ Referral Source/Agency: _____

Referral Name & Title: _____

Referral Phone #: _____ Referral Fax #: _____

Patient Name: _____ ☐ Male ☐ Female

DOB: _____ Medicaid ID Number: _____

Patient Phone Number: _____ Patient informed of referral? ☐ Yes ☐ No

Physical Address: _____ County: _____

Primary Language: ☐ English ☐ Spanish ☐ Other (specify): _____

Needs Interpreter: ☐ Yes ☐ No

Please include a current list of medications to help us provide more complete services

☐ No Medications

Reason for Referral:

☐ Advance Directives/End of Life Care Planning: _____

☐ Behavioral Health Needs: _____

☐ CHF: _____

☐ Chronic/Complex Medical Condition: _____

☐ Chronic Pain: _____

☐ COPD: _____

☐ CPS Involved – CPS Worker/Phone Number: _____

☐ Diabetes: _____

☐ Financial/Housing/Community Resource Needs: _____

☐ Pharmacy/Medication needs: _____

☐ Repetitive Use of ED Services/Multiple Hospitalizations: _____

☐ Social Concerns/Family Support: _____

☐ Transportation Needs: _____

☐ Other/Pertinent Medical History: _____