Pediatric Care Management Referral Form

Community Care of North Carolina

Date: _____ Referral Source/Agency: _____

Referral Name & Title: _____

Referral Phone #: _____ Referral Fax #: _____

Patient Name: _____ DOB: _____ ☐ Male ☐ Female

Patient Social Security #: _____ Parent/Guardian informed of referral: ☐ Yes ☐ No

Parent/Guardian's Name & Phone #(s): _____ #: _____

Physical Address: _____ County: _____

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

Needs Interpreter: ☐ Yes ☐ No

For children 0-3 yrs, refer directly to CDSA if concern is primarily developmental

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

☐ No Medications

Referrals for Children aged 0 to 5th birthday

Can have any insurance or no insurance

☐ Medicaid ID: _____ ☐ Uninsured ☐ Private Insurance

☐ Asthma: _____ ☐ Diabetes: _____

☐ Child w/ Behavioral Health Concerns: _____ ☐ Child in Foster Care Program

☐ Child who is exposed to toxic stress:

- ☐ Current domestic/family violence
- ☐ Health/safety needs
- ☐ Homeless/living in shelter
- ☐ Neglect
- ☐ Parental rights terminated in the past
- ☐ Parent/guardian with substance abuse/mental health condition
- ☐ Unsafe/unstable environment

☐ Child with Special Healthcare Needs (chronic (> 12 mos.) physical, behavioral, or emotional condition)
Please specify: _____

☐ CPS/Foster Care Involved – Phone Number: _____ ☐ Needs Medical Home

☐ Repetitive Use of ED Services/Multiple Hospitalizations ☐ Other (Please specify): _____

Referrals for Children aged 5-20 years

Must have Community Care of North Carolina/Carolina ACCESS (CCNC/CA) or NC Health Choice

☐ Medicaid ID #: _____ ☐ Transportation Needs: _____

☐ Asthma: _____ ☐ Diabetes: _____

☐ Child w/ Behavioral Health Concerns: _____ ☐ Child in Foster Care Program

☐ Child with Special Healthcare Needs (chronic (> 12 mos.) physical, behavioral, or emotional condition)
Please specify: _____

☐ CPS/Foster Care Involved – Phone Number: _____ ☐ Needs Medical Home

☐ Repetitive Use of ED Services/Multiple Hospitalizations

☐ Pharmacy/Medication needs: _____

☐ Other (Please specify): _____