



Adult Care Management Referral Form

Date: _____ Referral Source/Agency: _____

Referral Name & Title: _____

Referral Phone #: _____ Referral Fax #: _____

Patient Name: _____ Patient Social Security #: _____

DOB: _____ Medicaid ID #: _____ Male Female

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: _____

APS Involved - APS 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: _____

Please call (1-877-566-0943) for referral questions | Fax completed form to (1-833-282-0884)

Visit our website at www.communitycarenc.org

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