Community Care OF NORTH CAROLINA

Pediatric Care Management Referral Form

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

Referral & Patient Information			
Referral Date:	Referral Source/Agency:		
Referral Name:		Referral Phone:	
Referral Title:		Referral Fax:	
Patient Name:		DOB:	☐ Male ☐ Female
Patient Social Security Number:		Parent/Guardian informed of referral: ☐ Yes ☐ No	
Physical Address:		County:	
Parent/Guardian Name:		Parent/Guardian Phone:	
Primary languages: ☐ English ☐ Spanish ☐ Other _____		Needs interpreter: ☐ Yes ☐ No	
Please include a current list of medications to help us provide more complete services.		☐ No medications	

Referrals for children aged 0-5 years

Please consider referring to the CMARC (Care Management for At Risk Children)/C4CC (Care Coordination for Children) program at the health department. A referral form can be found here: http://ccnc.care/cc4creferral.

Referrals for children aged 5-20 years*

☐ Medicaid ID:	☐ Transportation needs:	☐ Child in foster care program
☐ Behavioral health concerns:	☐ Asthma:	☐ Diabetes:
☐ Child exposed to toxic stress (*please specify*):	☐ Current domestic/family violence ☐ Neglect ☐ Homeless/living in shelter ☐ Parental rights terminated in past	☐ Health/safety needs ☐ Unsafe/unstable environment ☐ Parent/Guardian with substance abuse/mental health condition
☐ Child w/ special health care needs – chronic (>12 mos.) physical/behavioral/emotional condition (*please specify*):		
☐ CPS/Foster care involved; if yes, Phone:		☐ Needs medical home
☐ Repetitive use of ED services/multiple hospitalizations		☐ Pharmacy/medication needs:
☐ Other (*please specify*):		

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

Please fax completed form to 1-833-282-0884 and call 1-877-566-0943 for referral questions. Visit our website at www.communitycarenc.org.

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