Community Care OF NORTH CAROLINA

Adult Care Management Referral Form

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:		Medicaid ID:	
Physical Address:		County:	
Patient informed of referral: ☐ Yes ☐ No		Patient 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	

Reason for Referral
☐ Advance Directives/End of Life Care Planning:
☐ Behavioral Health Needs:
☐ CHF:
☐ Chronic Pain:
☐ COPD:
☐ APS involved; if yes, APS Worker/Phone:
☐ 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 fax completed form to 1-833-282-0884. If you have questions about your referral, call 1-877-566-0943 or visit CCNC's website at www.communitycarenc.org.