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 Title:	
Referral Email:	Referral Phone:	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 If you have questions about your referral, call 1-877-566-0943 or visit CCNC's website at www.communitycarenc.org.

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