Care Management Referral Form

DIRECTIONS:

For Medi-Cal members, email the completed form to CASHP.ACM.CMA@healthnet.com in a HIPAA-secure, encrypted manner or fax it to 1-866-581-0540 with a fax cover sheet to hide any protected health information (PHI).

Part 1: Referring Source

First and last name:		Referral date:
Office contact person:	Phone number:	Fax number:

Part 2: Member Information

Member first and last name:	Member ID#:	Date of birth:
Member address:	City:	ZIP code:
Member phone number:		

Member Diagnosis/Health Condition (check all that apply):

- ☐ Asthma
- ☐ Back pain
- ☐ Behavioral health
  - ☐ Depression
  - ☐ Anxiety
  - ☐ Autism
  - ☐ Other (specify) _____
- ☐ Congestive heart failure
- ☐ COPD
- ☐ Cystic fibrosis
- ☐ Diabetes
- ☐ Hemophilia
- ☐ Cancer
- ☐ HIV/AIDS
- ☐ Hypertension
- ☐ Kidney disease
- ☐ Obesity-weight management
- ☐ High-risk pregnancy
  Estimated date of delivery (EDD): __/__/__
- ☐ Prematurity and/or developmental delays
- ☐ Sickle cell disease
- ☐ Hepatitis
- ☐ Transplant
- ☐ Traumatic brain injury
- ☐ Other:_____

Please check if any of the following referral reasons apply to the member:

- ☐ Member needs prenatal care education and support services.
- ☐ Member needs disease management/health coaching for his/her illness or condition.
- ☐ Member needs referral for: ☐ housing/shelter, ☐ food, ☐ other (specify) _____.
- ☐ Member needs education on prescriptions and compliance.
- ☐ Concerned about high emergency room utilization or frequent hospitalizations.
- ☐ Member needs transportation to medical appointments.
- ☐ Member needs assistance with medical equipment.
- ☐ Member needs assistance with behavioral health services.
- ☐ Safety concerns.
- ☐ Other (specify) _____

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