

Care Management Referral Form



DIRECTIONS:

To refer a California Health & Wellness member to any of our care management programs or services (case management or disease management), fax this completed form to **1-855-556-7909** or mail it to: California Health & Wellness, 1740 Creekside Oaks Drive, Suite 200, Sacramento, CA 95833. If you have questions about how to complete this form, contact California Health & Wellness at **1-877-658-0305** and ask for case management.

Part 1: Referring Source

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

For which care management program/service are you making a referral? (check all that apply)

- Case Management Disease Management

Part 2: Member Information

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

<p>Member diagnosis/ health condition:</p> <p>(Check all that apply)</p>	<input type="checkbox"/> Asthma <input type="checkbox"/> Back pain <input type="checkbox"/> Behavioral health <input type="checkbox"/> Depression <input type="checkbox"/> Anxiety <input type="checkbox"/> Autism <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Congestive heart failure <input type="checkbox"/> COPD <input type="checkbox"/> Cystic fibrosis <input type="checkbox"/> Diabetes <input type="checkbox"/> Hemophilia <input type="checkbox"/> Cancer <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Hypertension	<input type="checkbox"/> Kidney disease <input type="checkbox"/> Obesity weight management <input type="checkbox"/> High-risk pregnancy <input type="checkbox"/> Prematurity and/or developmental delays <input type="checkbox"/> Sickle cell disease <input type="checkbox"/> Smoking cessation <input type="checkbox"/> Hepatitis <input type="checkbox"/> Transplant <input type="checkbox"/> Traumatic brain injury <input type="checkbox"/> Other: _____
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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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