Care Coordination Referral Form

Columbia Pacific CCO™
Part of the CareOregon Family

Please fill out both pages with as much information as possible.
If you do not hear from us within one (1) business day, please call 503-416-3731.

Referrer information

Date of referral: _____/_____/_____

Referred by: _____ **Contact phone #:** _____
(Person completing this form preferred) (Direct number preferred)

Relation to member: _____ **Agency/role** (If applicable): _____

If referrer is not the member, is the member aware of this referral? ☐ Yes ☐ No

Member name: _____

Date of birth: _____/_____/_____ **Member ID:** _____

Request for care coordination assistance for: *(Please check all that apply)*

- ☐ Request for Case Consultation/ ICT Meeting
- ☐ Provider access
- ☐ Complex medical condition(s)
- ☐ Behavioral health support
- ☐ Self-management coaching and support
- ☐ Transition of care support
- ☐ Multiple ED or IP admission
- ☐ Community-based resource support
- ☐ Substance use support
- ☐ Other (Describe) _____

Please provide details below regarding the reason for referral/issues of concern:

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Member information

Member preferred name: _____

Pronouns: _____ **Language:** _____

Member phone/alternative contact: _____ Okay to leave voicemail? ☐ Yes ☐ No ☐ Unknown

Parent/guardian name and contact info (if applicable): _____

Preferred method of communication: ☐ Phone ☐ Text ☐ E-Mail _____ ☐ Unknown

DHS or I/DD caseworker? ☐ Yes ☐ No **Phone:** _____ **Fax/e-mail:** _____

What is member's current housing? ☐ Housed ☐Temporary housing ☐ Homeless ☐ Unknown

Member physical address (please include the county the member lives in):

_____

Member mailing address (if different than above):

_____

Health plan:
☐ CareOregon Advantage ☐ OHP- Columbia Pacific (CPCCO) ID#: _____

Other health insurance: ☐ Yes ☐ No If yes, insurance carrier and ID#: _____

Native American/Alaskan Native: ☐ Yes ☐ No **Tribal affiliation:** _____

Member's PCP (if known): _____ **Phone:** _____

Mental health provider/agency (if known): _____ **Phone:** _____

If member is 17 or younger, please fill out the following if known/applicable:

Current school: _____ **Grade:** ____ **School contact:** _____

IEP? ☐ Yes ☐ No **Phone:** _____ **Fax/email:** _____

Other supports/systems involved: _____

Phone: _____ **Fax/email:** _____

Please send this form and any relevant chart notes or supporting documents by fax to: **503-416-3676** or secure e-mail to: *ccreferral@careoregon.org*