

Care Coordination Referral Form



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)*

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

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/alt. 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- Jackson Care Connect 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