CONIFER
HEALTH SOLUTIONS®

CASE MANAGEMENT Referral Form FAX completed form to (818) 817-5155 or (714)590-5107

Date	Name/Title Referring Person:		
	Referring Person phone number:		
Referral Priority Level	☐ Urgent (outreach 2 business days) ☐ Routine (outreach 5 business days)		
Member Name		Date of Birth	Phone Number
MemberID#	IPA Name	Health Plan	
Family/Caregiver Contact Name and Phone number			

Reason for Referral to Case Management (Select all that apply):

☐	Frequent ER visits (Two in last 3 months)	☐	Coordination of Authorizations
☐	Frequent Hospitalization (Two in last 6 months)	☐	New Diagnosis
☐	Symptom Management (i.e. Pain, CHF, Pulm)	☐	New to Group/COC needs
☐	Caregiver or Family Support Issues	☐	Self-Management Education
☐	Home/Environmental Concerns	☐	Medical Plan Noncompliance
☐	DME needs	☐	Transplant (Potential or Actual)
☐	Transportation Needs	☐	CPS or APS
☐	Poly- Pharmacy	☐	CCS aging out

Brief Clinical History related to this Referral

Primary Diagnosis	ICD 10 code	Secondary Diagnosis	ICD 10 code

Comorbidities

Describe Specific Concerns for this Member

< Case Management Department Only Below >

Date Referral Received:	
CM Assigned	CM Notified Date
PCC Assigned	PCC Notified Date