Care Management Referral Form

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Date of referral: _____

Referring source: _____

Patient name: _____

DOB: _____

Best #(s) to reach patient: _____

Patient email: _____

Health plan: _____

PCP: _____

RISK

Reason for referral: _____

Is this a patient you are concerned may end up in the hospital in the next 3 months? [ ] Yes [ ] No

SYMPTOM RECOGNITION/DISEASE MANAGEMENT

1. Is this patient able to manage and recognize symptoms of their disease(s)? [ ] Yes [ ] No

Briefly explain: _____

2. Does the patient have a treatment plan that he/she is not adhering to? [ ] Yes [ ] No

Briefly explain: _____

HOME SAFETY

1. Any functional concerns that impair the patient from managing their care at home? (i.e., lack of assistive devices, unable to complete ADLs) [ ] Yes [ ] No

Briefly explain: _____

2. Needing higher level of care or lack of caregiver support in home? [ ] Yes [ ] No

Briefly explain: _____

MEDS

1. Any medication management concerns? [ ] Yes [ ] No

Briefly explain: _____

NEXT UPCOMING APPOINTMENTS

Date(s): _____

Provider name(s): _____

Specialties: _____

North State Quality Care Network
A Dignity Health Member