## 



**Case Coordination / Management Referral Form**

**UCare Fax: 612-884-2066**

Fax: 612.884.2497

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| --- | --- | --- | --- | --- | --- | --- |
| Product: | | | | | | |
| **Patient Information** | | | | | | |
| Patient Name: | Date of Birth: | | | | UCare ID#: | |
| Mailing Address: | | County: | | | Phone: | |
| Member speaks:  English  Burmese  Hmong  Karen  Spanish  Somali  Russian  Other: | | | | | Interpreter Needed:  Yes  No | |
| **Referral Source** | | | | | | |
| Name of person referring: | | | | Phone: | | |
| Clinic/County/Organization: | | | Do you want to be contacted regarding this referral?  Yes  No | | | |
| **Provider Information (if known)** | | | | | | |
| Primary Care Provider/Title: | | | | | | Phone/Fax: |
| Primary Care Clinic: | | | | | | |
| Case Manager/County Worker: | | | | | | Phone/Fax: |
| Other Specialist/Clinic: | | | | | | Phone/Fax: |
| Power Of Attorney / Authorized Representative / Parent: | | | | | | Phone: |
| Relationship to Patient: | | | | | | Consent Form Needed?  Yes  No  Unknown |
| **Reason for Referral** | | | | | | |
| Reason for Referral/Diagnosis: | | | | | | |

\*Attach any supporting documentation that maybe helpful in processing this referral for case management.