## 

**Complex Case Management Referral Form**

Fax: 612.884.2497



|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| 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: | | |
| Diagnosis: | | | | | | | |
| Date and Location of most recent hospitalization (if appropriate): | | | Do you want to be contacted regarding this referral?  Yes  No | | | | |
| **Provider Information (if known)** | | | | | | | |
| Primary Care Provider/Title: | | | | Phone: | | | Fax: |
| Primary Care Clinic: | | | | Phone: | | | Fax: |
| Power Of Attorney/ Authorized Representative: | | | | 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.