##

 **Complex Case Management Referral Form**

 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:        |
| 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.