CenCal HEALTH™
The Regional Health Authority

# *Care Management Referral Form*

## Please fax to (805) 685-5191

Please print or type information below:

**PATIENT INFORMATION**

| Patient Last Name | Patient First Name | M.I. | Date of Birth |
|---|---|---|---|
| | | | |

| Member ID Number | Full Address | Phone Number |
|---|---|---|
| | | |

**REFERRAL INFORMATION**

| Referring Physician Last Name | Physician First Name | Phone Number |
|---|---|---|
| | | |

Fax Number

**REASON(S) FOR REFERRAL TO CENCAL HEALTH CARE MANAGER, RN:**

- ☐ Medication non-compliance
- ☐ Diabetes
- ☐ Asthma
- ☐ High risk OB
- ☐ Morbid Obesity
- ☐ Catastrophic/Medically Complex Case
- ☐ Psychosocial factors presenting barriers to care
- ☐ Terminal Illness
- ☐ Educational Coaching would benefit patient
- ☐ Other

**CLINICAL INFORMATION**

X _____ _____ _____

Signature of person completing form | Fax Number | Date

*Thank you for the referral!*

April 2009