Care Coordination Referral Form

To be eligible for services, patient must be a Patient First Medicaid recipient

417 20th Street North, Suite 1100
Birmingham, AL 35203

For questions, please call: (205) 558-7660
Toll Free: (855) 698-2273
Fax: (205) 449-9759

Name: _____ Date of Birth: _____

Parent/Guardian (if applicable): _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Cell: _____ Medicaid #: _____

Hospital Referral? ☐ Yes ☐ No Discharge Date: _____

Provider Referral? ☐ Yes ☐ No Last Visit Date: _____

Reason for Care Coordination/Transitional Care/Behavioral Health:

- ☐ Non Compliance:
  - ☐ Regular visits ☐ Medication ☐ Other
- ☐ Medication Management Issues
- ☐ Weight Management Height: _____ Weight: _____
- ☐ Inappropriate ED Utilizations
- ☐ Frequent Hospitalizations
- ☐ Diagnosis: _____ ☐ Newly Diagnosed ☐ If Diabetic, A1C Level: _____ Date Obtained: _____
- ☐ Education
- ☐ Care Coordination/Transitional Care/Behavioral Health
- ☐ Patient wants follow-up with medical doctor
- ☐ Patient wants follow-up with behavioral health clinician:
  - ☐ Psychiatry ☐ Substance Abuse ☐ Counseling

Additional Patient Needs:

- ☐ Complex Social Issues:
  - ☐ Housing ☐ Food ☐ Financial ☐ Transportation ☐ Other
- ☐ Developmental Delay
- ☐ Dietary
- ☐ Parenting Issues
- ☐ Other: _____

Additional Comments: _____

_____

Was the patient or family informed of the referral? ☐ Yes ☐ No
If not, please inform patient that they will be contacted. Thank you.

Person Referring: _____ Phone: _____

Referring Agency: _____ Date of Referral: _____

Please provide your desired method of contact (direct phone number, email, or confidential fax number) for referral receipt confirmations and patient updates _____.
All emails will be sent securely via encryption.

Please fax completed form to: (205) 449-9759

For ACP Use Only:

- ☐ Assign to Care Coordinator/Nurse
- ☐ Requested additional information from PMP
- ☐ Referral declined; letter sent

*Revised 1/11/2017