

Complex Care Case Management Referral

Date: _____

Member Name: _____ DOB: _____ CareOregon ID#: _____

Members PCP: _____ PCP Phone: _____

Referring Clinic: _____

Contact Person: _____ Contact Telephone #: _____
(Person completing this form preferred) *(Direct number preferable)*

Request for CareSupport Team Assistance for:
(Please check all that apply)

- Self-management coaching and support
- Help with access to medical services
- Referral for severe mental health issues
- Coordination of information between clinicians/service providers
- Help finding critical community resources
- High ED use/recurrent avoidable hospitalizations

Please provide details (if necessary) regarding the reason for referral/issues of concern:

Please fax this form and relevant chart notes/problem list.

Fax to: (503) 416-3676