



****Proprietary & Confidential****

**CARE COORDINATION REFERRAL FORM to the SYNERGY PROGRAM
(For members with a diagnosis of Diabetes or Depression – or at risk of - only)**

Client Referral Source (required)	
Name:	
Department/Title:	
Date:	
Phone/Extension:	

Member Information (required)			
Name:		Member ID#:	
Address:		DOB:	
City/State:		Phone #:	

Rx, Medical and Behavioral Diagnoses and Treatment History (any additional information is helpful)	
Rx (include medication and dose if available):	
Medical:	
Behavioral:	
Other:	

Referral Reason and Details	
<input type="checkbox"/> CM <input type="checkbox"/> UM <input type="checkbox"/> Maternity <input type="checkbox"/> Rx <input type="checkbox"/> DM <input type="checkbox"/> QI <input type="checkbox"/> Consult	
Referral Details (reason for referral):	

Referral Disposition	
<input type="checkbox"/> In Progress <input type="checkbox"/> Pending <input type="checkbox"/> Resolved	
Comments:	

Email to SynergyMemberReferrals@healthintegrated.com or Fax to: 1-888-708-0684

Attn: Susan Casper, Leslie Stachelski, LeDonna Chambers

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This form must be maintained and shared ONLY in a HIPAA compliant format (e.g. facsimile, secure email, U.S. Mail).