

## 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)*

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**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

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

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

**Fax to: (503) 416-3676**