Care Coordination Referral

Date: _____

Member name: _____**DOB:** _____**CareOregon ID#:** _____

Member address: _____**Member phone:** _____

Alternative contact: _____

Member's PCP: _____ **PCP phone:** _____

Referring provider/clinic: _____

Assigned Regional Care Team *(if known)*: _____

Contact person: _____ **Contact phone:** _____
(Person completing this form preferred) *(Direct number preferable)*

Request for Care Coordination team assistance for:

(Please check all that apply)

☐ Access to/establish with PCP	☐ Chemical dependency support
☐ Access to/establish with Specialty Care Provider	☐ MH/BH barriers to access
☐ Chronic condition management	☐ MH/BH recourse inquiry
☐ Dental needs	☐ Referral to establish with MH/BH provider
☐ End of life support	☐ Activities of daily living (ADL)/social needs
☐ Hearing needs	☐ Benefit advocacy
☐ Medication assistance	☐ Durable medical equipment support
☐ Pain management	☐ Other (Describe):
☐ Vision needs	_____

Please provide details about the reason for referral/issues of concern:

_____

_____

_____

_____

_____

Please fill out these Care Coordination Referral intake questions:

What is member's current living situation?
- ☐ Permanent housing
- ☐ Temporary housing
- ☐ Transitional housing
- ☐ Homeless
- ☐ Unknown

Is member able to attend to own ADLs (bathe, dress, transfer, toilet, eat, etc.)?
- ☐ Yes
- ☐ No
- ☐ Unknown

Is member able to attend to own IADLs (cook, clean, finances, shop, meds, phone, etc.)?
- ☐ Yes
- ☐ No
- ☐ Unknown

Can member get to the bathroom on time?
- ☐ Yes
- ☐ No
- ☐ Unknown

Has member fallen in the past 12 months?
- ☐ Yes
- ☐ No
- ☐ Unknown

Is member afraid of falling?
- ☐ Yes
- ☐ No
- ☐ Unknown

Does member have a caregiver?
- ☐ Yes
- ☐ No
- ☐ Unknown

Does member have an APD worker?
- ☐ Yes
- ☐ No
- ☐ Unknown

Are there religious, cultural, or family beliefs that affect how the member uses the health care system?
- ☐ Yes
- ☐ No
- ☐ Unknown

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

Fax to: 503-416-3676