

Referral form

*Member's full name:	*DOB:
Member's preferred phone number:	
*Your name:	
*Your contact information:	
*Date of referral:	

* Required fields

Indicate the desired program(s) to which you would like to refer this member. <input checked="" type="checkbox"/> Check all boxes that apply.	
<input type="checkbox"/> Asthma (ages 5+)	<input type="checkbox"/> Newly diagnosed with asthma <input type="checkbox"/> Two or more hospitalizations and/or ER visits for asthma within the previous 12 months <input type="checkbox"/> Has asthma and has needs related to: <ul style="list-style-type: none"> • Education about the disease • Self-management • Medication adherence
<input type="checkbox"/> COPD	<input type="checkbox"/> Newly diagnosed with COPD <input type="checkbox"/> Two or more hospitalizations and/or ER visits for COPD within the previous 12 months <input type="checkbox"/> Has COPD and has needs related to: <ul style="list-style-type: none"> • Education about the disease • Self-management • Medication adherence
<input type="checkbox"/> Cardiac disease	<input type="checkbox"/> Two or more hospitalizations and/or ER visits for cardiac disease within the previous 12 months <input type="checkbox"/> Had a recent cardiac event (CHF, CABG, MI, PTCA) and/or unstable angina <input type="checkbox"/> Had a past cardiac event (CHF, CABG, MI, PTCA) and/or unstable angina and has needs related to: <ul style="list-style-type: none"> • Education about the disease and self-management • Medication adherence <input type="checkbox"/> Has high blood pressure and has needs related to: <ul style="list-style-type: none"> • Education about the disease and self-management • Medication adherence <input type="checkbox"/> Has hyperlipidemia and has needs related to: <ul style="list-style-type: none"> • Education about the disease and self-management • Medication adherence

Indicate the desired program(s) to which you would like to refer this member.

Check all boxes that apply.

Heart failure

- Newly diagnosed with heart failure
- Two or more hospitalizations and/or ER visits for heart failure within the previous 12 months
- Has heart failure and has needs related to:
 - Education about the disease
 - Self-management
 - Medication adherence

Diabetes

- Newly diagnosed with diabetes or pre-diabetes
- Two or more hospitalizations and/or ER visits for diabetes within the previous 12 months
- Has diabetes and has needs related to:
 - Education about the disease
 - Self-management
 - Medication adherence

Behavioral health

- Two or more hospitalizations and/or ER visits for behavioral health conditions within the previous 12 months
- Has depression and has needs related to:
 - Education about the condition and/or
 - Advocacy and help accessing behavioral health providers
- Has anxiety and has needs related to:
 - Education about the condition and/or
 - Advocacy and help accessing behavioral health providers
- Has a chronic condition and needs coordination (Describe in Comments section.)

Quit to Win
(*smoking cessation program*)

- Quit to Win program information only
- Ready to quit and wants to start program

Comments:

Thank you for your referral!

Please fax this completed form to Clinical Integration at 1-508-368-9030.
If you have any questions, please call the Clinical Integration Department at
1-508-799-2100, ext. 78002, Monday through Friday from 8:30 a.m. to 5:00 p.m.

