PacificSource Community Health Plans
2965 NE Conners Avenue, Bend, OR 97701
541.385.5315 888.863.3637
Medicare.PacificSource.com

Care Coordination Referral Form

This form is for coordination between providers and PacificSource Medicare. **Please include any relevant medical records with this form.** Please fax completed form to: **(208) 433-4625.**

Submitted Date:	Referrer Name:	
Phone:	Fax:	
Patient Information		
Member Name: (First, M.I. Last)		
Member ID:	DOB:	Phone:
Provider Information		
Mental Health Provider:		Phone:
Alcohol/Drug Provider:		Phone:
Physical Health Provider:		Phone:
Other:		Phone:

Reasons for Referral to Care Coordination/Case Management (at least two must be checked)

Care Management

- ☐ Two or more inpatient admissions within the last year
- ☐ Hospital re-admission within 30 days of discharge
- ☐ Two or more ER visits within the last six months
- ☐ No PCP within the last year
- ☐ Significant impairment in two or more activities of daily living, particularly when there is inadequate support systems (i.e. trauma, brain injury, burns)
- ☐ ER visit or inpatient admission with a comorbid behavioral health condition

Medication Therapy

- ☐ Medication review by pharmacist

Other

- ☐

_____

_____

Substance Abuse

☐ Active substance abuse or dependence (list drug(s) of abuse or dependence):

_____
_____
_____

Diagnosis

☐ Behavioral Health (BH) diagnoses:

_____
_____
_____

☐ Physical Health (PH) diagnoses:

_____
_____
_____

☐ Comorbid BH and PH diagnoses:

_____
_____
_____

☐ Chronic pain, exhausted resources:

_____
_____
_____

Intervention Tried – All Categories

Brief Description of Referral Need

☐ Member agrees to referral ☐ Member has not been contacted