

**Care Management Programs
Referral/Communication Form**
Referrals may be faxed to: 1 352-337-8698
For assistance please call: 1 800-972-8633

Member Name: _____ **ID#:** _____

Care Management Program (check all that apply):

Asthma High-Risk OB Complex Case Management Oncology

CHF EF% _____ Test Performed Date ____/____/____

Diabetes HbA1C _____ Test Performed Date ____/____/____

CAD LDL _____ Test Performed Date ____/____/____
Hx of MI, Bypass Surgery (last 6 months)

CKD Serum Creatinine _____ (>1.2 for women) Date ____/____/____
Serum Creatinine _____ (>1.5 for men) Date ____/____/____

ESRD Dialysis Start Date _____

Transplant- New Referral Post Transplant (Date of Transplant) _____

Wound Care Chronic Wound > 6wks

Wound Type: Pressure Venous Arterial Diabetic Surgical Other: _____

Wound Care Modality Specify _____

Other (Please describe) _____

Member History (reason for referral): _____

Referring Provider: _____ **Phone #** _____

Member's PCP: _____ **Phone #** _____

Specialist: _____ **Phone #** _____

Specialist: _____ **Phone #** _____

Specialist: _____ **Phone #** _____

Home Health Agency (if applicable) _____ **Phone #** _____

Wound Care Clinic (if applicable) _____ **Phone #** _____

Final Case Disposition (Care Management Use Only):

Enrolled Date ____/____/____ Case Closed Date ____/____/____

Other: _____

Care Coordinator: _____

Phone # & Ext. _____ **Fax #** _____