

Care Management Referral Form

Cullman, Limestone, Madison, Morgan, Marshall, and Jackson Counties

Form must be completely filled out in order to be processed

Eligible Individual Name: _____ Date: _____

DOB: _____ Sex _____ EI / Guardian Phone # _____

Medicaid #: _____ Primary Language: _____

Home Address to include city and zip: _____

Emergency Contact: _____ Phone: _____

Referring Physician / Facility: _____

Contact Name: _____ Phone/Email: _____

Medical Diagnoses (Not required to make a referral):

- | | | |
|--|--|---|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> BMI greater than 25 | <input type="checkbox"/> Substance Disorder |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> COPD | <input type="checkbox"/> HIV |
| <input type="checkbox"/> Sickle Cell | <input type="checkbox"/> Cancer | <input type="checkbox"/> Mental Illness |
| <input type="checkbox"/> Hepatitis C | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Organ Transplant |
| <input type="checkbox"/> Other _____ | | |

Reason for Referral

- | | | |
|---|--|---|
| <input type="checkbox"/> Informatics--Reviewed Quality Measures | <input type="checkbox"/> NET Transportation Assistance | <input type="checkbox"/> Disease Education |
| <input type="checkbox"/> Behavioral Health | <input type="checkbox"/> Housing | <input type="checkbox"/> Substance Abuse Services |
| <input type="checkbox"/> Other _____ | <input type="checkbox"/> Medication Management | <input type="checkbox"/> Maternity Services |
| | <input type="checkbox"/> Community Resources | <input type="checkbox"/> Family Planning |

Special Instructions / Pertinent Information

Send Referral form to
Fax: (256) 382-2715
Email: Referrals@northalabamacommunitycare.org