

CARE MANAGEMENT REFERRAL FORM

FAX BACK TO : (909) 620-8092

ATTN: CM DEPT.

Member Name:	Date of Birth:
Member ID #:	Primary Care Physician:

Referral Source (i.e. doctor, provider group, discharge planner, social worker, other):

Primary Diagnosis:

Other Diagnoses:

Disease/Care Management Criteria

Diabetes

A1C

Date/result: _____

CHF

Echocardiogram (Ejection Fraction)/Stage

Date/result: _____

Complex Care Management:
Reason for referral:

Additional Information:

Records attached: H&P LABS Consults/Reports

Referred By: _____ Phone: _____

Fax number: _____ Date: _____