Referral to Care Management Team

Referral Line Phone: 1-866-534-4638
Fax: 860-812-2209

Referral Source Name: _____

Phone: _____

Date of Referral: _____

I. Patient Demographic Information:

Name:_____ DOB:_____

Patient Contact #:_____ PCP: _____

Responsible Contact:_____ Phone: _____
(if applicable)

Is the patient or responsible contact aware of the referral? ☐ Yes ☐ No

II. General Area of Support Requested:

☐ **Care Coordination** (assistance making appointments, acquiring medical, transportation, Caregiver Support, etc)

☐ **Social Determinants of Health** (concerns regarding access to food, housing, clothing, utilities, financial assistance, insurance needs, coordination of community resources, etc)

☐ **High Risk Pharmacy** (medication education, >10 medications, financial access to medications)

☐ **Pre-Disease/Disease Management** (smoking cessation, BMI>30, prediabetes, new diagnosis of a chronic condition or at risk for disease progression i.e. diabetes, HTN, CHF)

☐ **Complex Care** (polychronic, high utilization, goals of care, advanced CHF/COPD)

☐ **Behavioral Health** (positive depression screening, substance abuse, coordination of psychiatric services)

III. Specific Concerns:

IV. Priority:

☐ High (within 1-3 business days) ☐ Moderate (within business 4-7 days) ☐ Low (within 1-2 weeks)