



# Care Coordination Referral Form

Patient Name: \_\_\_\_\_ Date of Referral: \_\_\_\_\_

**Please attach demographic face sheet that includes:** date of birth, physical address, all phone numbers, Medicaid ID, and name of guardian (if applicable)

**Please attach current medication list**

Provider Name: \_\_\_\_\_

### REASON FOR CARE COORDINATION REFERRAL:

Diagnosis/Diagnoses related to referral: \_\_\_\_\_  New Diagnosis

Diabetes, A1c level: \_\_\_\_\_ Date obtained: \_\_\_\_\_

Non-compliance  
 Clinic visits     Medication     Other: \_\_\_\_\_

Disease/Condition Education

Medication Education

Inappropriate ED Utilization

Frequent Hospitalizations

Transportation Issues

Patient needs follow-up with specialist

Patient needs follow-up with behavioral health  
 Psychiatry     Substance Abuse     Counseling

Other: \_\_\_\_\_

Additional Comments: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Office Contact Person: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**PLEASE FAX COMPLETED FORM TO (334) 460-1272**

1445 S. College Street | Suite 300 | Auburn, Alabama 36830  
Fax: (334) 460-1272

Administered by: VIVA HEALTH®

Nondiscrimination Notice:

CARE NETWORK OF ALABAMA complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Language Assistance Services:

Spanish

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-902-2425 (TTY: 711).

Chinese

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-855-902-2425 (TTY: 711)。