



INDIVIDUAL CASE MANAGEMENT/ DISEASE MANAGEMENT REFERRAL FORM

This form should be filled out completely. Please print.

Fax completed form to 1-205-733-7253.

Please check (✓) the appropriate box.

Case Management Referral <input type="checkbox"/>	Transitions of Care Referral: <input type="checkbox"/> Post-hospitalization for Congestive Heart Failure <input type="checkbox"/> Coronary Arterial Bypass Graft (CABG)		
Disease Management Referral: <input type="checkbox"/> Asthma <input type="checkbox"/> Coronary Artery Disease (CAD) <input type="checkbox"/> Chronic Obstructive Pulmonary Disease (COPD) <input type="checkbox"/> Diabetes <input type="checkbox"/> Heart Failure			
Urgent Referral <i>(Please contact me.)</i> <input type="checkbox"/>	Informational Referral Only <i>(Do not contact me.)</i> <input type="checkbox"/>		Referral Date

Patient Information

<input type="checkbox"/> Mr. <input type="checkbox"/> Ms. <input type="checkbox"/> Miss <input type="checkbox"/> Mrs. <input type="checkbox"/> Dr.	Date of Birth	Social Security Number	<input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/>
First Name	Middle Initial	Last Name	
Address			
City	State	Zip	County
Home Telephone <i>(+ Area Code)</i>	Work Telephone <i>(+ Area Code)</i>	E-mail	

Insurance Information

Group Name				
Contract Number <i>(include prefix)</i>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Group Number	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Insurance Start Date
Person Insured		Relationship to Patient		

Physician Resources

Physician First Name	Middle Initial	Last Name		
National Provider Identifier (NPI)	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Specialty		
Office Contact		Hospital/Clinic		
Address				
City	State	Zip	County	
Office Telephone	Fax Number		E-mail	

Diagnosis Information

Date of Last Hospitalization	Hospital			
Diagnosis	Referring diagnosis (if different)			
Brief Clinical History and Plan of Treatment				
Medications				
List any additional medical support provided (such as home health, IV infusions, etc.)				
Patient Functional Status: <input type="checkbox"/> Alert <input type="checkbox"/> Confused <input type="checkbox"/> Agitated <input type="checkbox"/> Disoriented <input type="checkbox"/> Comatose <input type="checkbox"/> Ambulatory <i>(Select all that apply.)</i>				
Primary Caregiver			Telephone <i>(+ Area Code)</i>	
Social Issues that will Help/Hinder Case Management				

I certify this information is complete and correct to the best of my knowledge.	Signature	Title	Date
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