



INDIVIDUAL CASE MANAGEMENT/ DISEASE MANAGEMENT REFERRAL FORM

Please fax the completed form to **205-402-9438** or **1-888-210-8225**.

This form should be filled out completely. Please print.

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 (Please contact me.) <input type="checkbox"/>	Informational Referral Only (Do not contact me.) <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"/>
First Name	Middle Initial	Last Name			
Address					
City	State	Zip	County		
Home Telephone (+ Area Code)	Work Telephone (+ Area Code)	E-mail			

Insurance Information

Group Name					
Contract Number (include prefix)	<input type="text"/>	Group Number	<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"/>	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: (Select all that apply.)	<input type="checkbox"/> Alert	<input type="checkbox"/> Confused	<input type="checkbox"/> Agitated	<input type="checkbox"/> Disoriented	<input type="checkbox"/> Comatose	<input type="checkbox"/> Ambulatory
Primary Caregiver	Telephone (+ Area Code)					
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 _____