Care Management Referral Form

Contact:
Care Management Team
661-716-7153
VIPNReferral@managedcaresystems.com

Date of referral:

Referring source:

Patient name:

DOB:

Best #(s) to reach patient:

Patient email:

Health plan:

PCP:

RISK

Reason for referral:

Is this a patient you are concerned may end up in the hospital in the next 3 months? [ ] Yes [ ] No

SYMPTOM RECOGNITION/DISEASE MANAGEMENT

1. Is this patient able to manage and recognize symptoms of their disease(s)? [ ] Yes [ ] No

Briefly explain:

2. Does the patient have a treatment plan that he/she is not adhering to? [ ] Yes [ ] No

Briefly explain:

HOME SAFETY

1. Any functional concerns that impair the patient from managing their care at home? (i.e., lack of assistive devices, unable to complete ADLs) [ ] Yes [ ] No

Briefly explain:

2. Needing higher level of care or lack of caregiver support in home? [ ] Yes [ ] No

Briefly explain:

MEDS

1. Any medication management concerns? [ ] Yes [ ] No

Briefly explain:

NEXT UPCOMING APPOINTMENTS

Date(s):

Provider name(s):

Specialties:

VIP Valley Integrated Provider Network