



Referral Date

Care Coordination Referral Form

Please transmit this form via secured email or fax the completed form with pertinent health records to [Care Coordination Help Desk](#) or **530-245-0612**.

To contact the Care Coordination Department and refer by phone, please call **(800) 809-1350**.

REFERRING PRACTITIONER OR FACILITY

Name:

Title:

Phone:

Fax:

Email:

Would you like to be contacted about this referral? Yes No

Was the member or authorized representative informed of this referral? Yes No

Is the member participating in any other programs? Yes No

If yes, please describe: (IOPCM, Whole Person Care, CCS, CBAS, etc.)

MEMBER INFORMATION

Member's Name:

Member CIN#

DOB:

Gender: Male Female Other:

Phone:

Language:

Street Address:

City, State, Zip:

County:

PCP:

Phone:

Fax:

Specialist:

Phone:

Fax:

Diagnosis:

Most recent hospitalization date:

Name of Hospital:

Please provide a brief description of why the member is being referred:

[Empty text box for description]

In all programs, we observe patient confidentiality at all times.

2525 Airpark Drive -- Redding, CA 96001