Referral Date

Care Coordination Referral Form

Please transmit this form via secured email or fax the completed form with pertinent health records to CareCoordination@partnershiphp.org or **707-863-4502.**
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:

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