PacificSource Community Solutions, Inc.
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Care Coordination Referral Form

This form is for coordination between providers and PacificSource Community Solutions, Inc.
Please include any relevant medical records with this form.

Please complete all fields, print for faxing, and fax to: **(541) 385-3123**

Submitted Date:	Referrer Name:	
Phone:	Fax:	
Patient Information		
Member Name: (First, M.I. Last)		
Member ID:	DOB:	Phone:
Provider Information		
Mental Health Provider:		Phone:
Alcohol/Drug Provider:		Phone:
Physical Health Provider:		Phone:
Other:		Phone:

Reasons for Referral to Care Coordination/Case Management (at least two must be checked)

Care Management

- ☐ Two or more inpatient admissions within the last year
- ☐ Hospital re-admission within 30 days of discharge
- ☐ Two or more ER visits within the last six months
- ☐ No PCP within the last year
- ☐ Significant impairment in two or more activities of daily living, particularly when there is inadequate support systems (i.e. trauma, brain injury, burns)
- ☐ ER visit or inpatient admission with a comorbid behavioral health condition

Medication Therapy

- ☐ Medication review by pharmacist

Substance Abuse

- ☐ Active substance abuse or dependence (list drug(s) of abuse or dependence):

  _____

  _____

Diagnosis

- ☐ Behavioral Health (BH) diagnoses:

  _____

- ☐ Physical Health (PH) diagnoses:

  _____

- ☐ Comorbid BH and PH diagnoses:

  _____

- ☐ Chronic pain, exhausted resources:

  _____

Other

- ☐ _____
- ☐ _____
- ☐ _____

Intervention Tried – All Categories

Brief Description of Referral Need

☐ Member agrees to referral ☐ Member has not been contacted