

Disease Management Referral Form

All information contained on this form is strictly confidential and may become part of your patient's record.

Member's information	
Member name:	Member DOB:
Member ID:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Member phone:	Alternate phone:
Referring provider name:	Referral date:
Referring provider phone:	Referring provider fax:
Health condition history	
<input type="checkbox"/> Asthma	<input type="checkbox"/> HIV/AIDS
<input type="checkbox"/> Bipolar disorder	<input type="checkbox"/> Hypertension
<input type="checkbox"/> Coronary artery disease	<input type="checkbox"/> Major depressive disorder — adult
<input type="checkbox"/> Congestive heart failure	<input type="checkbox"/> Major depressive disorder — child/adolescent
<input type="checkbox"/> Chronic obstructive pulmonary disease	<input type="checkbox"/> Substance use disorder
<input type="checkbox"/> Schizophrenia	
<input type="checkbox"/> Diabetes	
Insulin dependency? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Reason for referral	
Additional comments	
Please fax form back to: Disease Management 1-888-762-3199	

