

Community Care of Wake and Johnston Counties (CCWJC)

Adult Care Management Referral Form – CAROLINA ACCESS MEDICAID PATIENTS

Please fax completed form to (919) 510-9162

Date: _____ Referral Source/Agency: _____

Patient Name: _____ Male/Female (circle one)

DOB: _____ Medicaid ID Number: _____

Patient Phone Number: _____ Patient informed of referral? **Yes/No (circle one)**

Physical Address: _____ County: _____

Primary Language: English _____ Spanish _____ Other (specify): _____

Person Referring: _____ (MD, RN, SW, Other) **please circle**

Phone#: _____ Fax #: _____

Reason for Referral:

Asthma (please specify): _____

Repetitive Use of ED Services/Multiple Hospitalizations: _____

CHF (please specify): _____

Diabetes (please specify): _____

Social Concerns/Family Support (please specify): _____

Mental Health Concerns: _____

Financial/Housing/Community Resource Needs: _____

Transportation Needs: _____

Chronic/Complex Medical Condition(s) Requiring Care Management

Chronic Pain Concerns (specify): _____

Needs assistance in following plan of care for chronic illness (please specify): _____

For Care Manager's Use Only:

Date: _____

_____ Accepted into Care Management

_____ Other Interventions: _____