

Population Health Management Referral Form Case Management

Date of Referral:	
Member name:	Date of Birth:
Member address:	Member phone number:
Type of Case Management services needed: (che	eck one)
Disease Management	
Complex Case Management	
Reason for Case Management Services: (check a	ll that apply)
Difficulty controlling symptoms	Medication or treatment non-
	compliance
Assistance with self-management	Poly-pharmacy
Assistance with care coordination	Poorly controlled chronic conditions

Caregiver or social issues

Primary diagnosis:

Additional information:

Fax form with pertinent medical records and information to: Los Angeles County: (323) 889-6575 San Diego County: (619) 219-3302

Multiple hospital admissions or ER visits

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