# FIHN Care Management Referral

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|---|---|
| Date: | Referring MD: |
| ☐ Medicare | MD Preferred Contact Phone Number#: |
| ☐ FMH Employee Health Plan | |

Patient Demographics:

- Name:
- Date of Birth:
- Phone Number:

Reason for referral:

- ☐ Emergency Room High Utilizer
- ☐ Hospital readmission/frequent admissions

Services that may benefit this patient/family:

- ☐ Chronic Disease Management: education, support:
  - ☐ Heart Failure
  - ☐ COPD/Asthma/Pulmonary
  - ☐ Diabetes
  - ☐ Mental Health
  - ☐ Other
- ☐ Community Health Worker
- ☐ Medication Management Concerns
- ☐ Nutritional assessment, dietary education
- ☐ Social Work/Support/Community resource needs
- ☐ Transportation
- ☐ Needs assistance with Navigation, scheduling of appointments, tests, treatments
- ☐ Advance Directive/Advance Care Planning
- ☐ Substance Abuse/Addiction concerns

Additional Information/Concerns:

Would you like the Care Manager to communicate with you via:

- ☐ Phone
- ☐ Fax

Please provide a contact in your office for any questions and or follow up to the care managers interventions

- Name:
- Contact Phone Number:
- Fax Number:
- Alternate Contact at office:
- Contact Phone Number:

Referrals can be faxed to **240-566-7864**