

Community Care of Wake and Johnston Counties (CCWJC)
&
Care Coordination for Children (CC4C)
Pediatric Care Management Referral Form – *fax completed form to (919) 510-9162*

Date: _____ Patient Name: _____ DOB: _____
Male/Female (**circle one**) Parent/Guardian informed of referral: Yes/No (**circle one**)
Parent/Guardian's Name & Phone #(s): _____
Physical Address: _____ County: _____
Primary Language: English _____ Spanish _____ Other (specify): _____
Referral Source-Person: _____ (MD, RN, SW, Other) **please circle**
Agency _____ Phone: _____ Fax : _____

For children 0-3yrs, refer directly to CDSA if concern is primarily developmental

Referrals for Children aged 0 to 5th birthday

- Medicaid ID: _____ Uninsured Private Insurance
- Asthma _____ Diabetes _____ NICU Admission
- Repetitive Use of ED Services/Multiple Hospitalizations Needs Medical Home
- Child in Foster Care Program Child w/Mental Health Concerns _____
- Child with Special Healthcare Needs (chronic (> 12 mo) physical, behavioral, or emotional condition) (Please specify) _____
- Child who is exposed to toxic stress (**circle one**: current domestic/family violence, health/safety needs, neglect, unsafe/unstable environment, homeless/living in shelter, parent/guardian with substance abuse or mental health condition, parental rights terminated in the past)
- Other (Please specify): _____

Referrals for Children aged 5-20 years (*Must have Carolina Access Medicaid or Health Choice*)

- Medicaid ID #: _____ Asthma _____
- Diabetes _____ Transportation Needs _____
- Repetitive Use of ED Services/Multiple Hospitalizations _____
- Child with Special Healthcare Needs (chronic (> 12 mo) physical, behavioral, or emotional condition) (Please specify) _____
- Child w/Mental Health Concerns _____
- Other (please specify): _____

For Care Manager's Use Only:

Date: _____
_____ Accepted into Care Management
_____ Other Interventions: _____

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