

Community Care of Wake & Johnston Counties

Case Management Referral Form

Name of Clinic Making Referral _____

Date: _____

Patient Name: _____

DOB: _____ MID# _____

Parent's Name (if a minor): _____

Current Phone #: _____

Patient/Parent informed of referral: Y/N (please circle)

Reason for Referral:

_____ 1.) Asthma (Please specify) _____

_____ 2.) Repetitive use of Emergency Department services

_____ 3.) CHF (Please specify) _____

_____ 4.) Diabetes (Please specify) _____

_____ 5.) Social concerns/ Family support

_____ 6.) Mental Health Concerns _____

_____ 7.) Financial/Housing/Community Resource Needs

_____ 8.) Transportation Needs _____

_____ 9.) Chronic/Complex Medical Condition(s) Requiring Management

_____ 10.) Needs assistance in following plan of care for chronic illnesses
(Please specify) _____

Person Referring _____ (MD, RN, Social Worker, Other) please circle

Phone #: _____

Fax #: _____

Please fax this form to 919-510-9162

To find your case manager go to www.ccwjc.com, look under practice info and click on the Case Manager Practice Assignments document.

For Case Manager's Use only:

Date: _____

_____ Accepted into Case Management

_____ Other Interventions: _____

Revised 10/14/09