Community Care of Wake and Johnston Counties (CCWJC)

Adult Care Management Referral Form

Community Care of North Carolina/Carolina ACCESS (CCNC/CA) or NC Health Choice

Please fax completed form to (919) 723-9382

Date: _____ Referral Source/Agency: _____

Patient Name: _____ ◯ Male ◯ Female

DOB: _____ Medicaid ID Number: _____

Patient Phone Number: _____ Patient informed of referral? ◯ Yes ◯ No

Physical Address: _____ County: _____

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

Needs Interpreter: ◯ Yes ◯ No

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

Phone#: _____ Fax #: _____

Please include a current list of medications to help us provide more complete services

☐ **No Medications**

Reason for Referral:

☐ **Advance Directives/End of Life Care Planning:** _____

☐ **Behavioral Health Needs:** _____

☐ **CHF:** _____

☐ **Chronic/Complex Medical Condition:** _____

☐ **Chronic Pain:** _____

☐ **COPD:** _____

☐ **CPS Involved – CPS Worker/Phone Number:** _____

☐ **Diabetes:** _____

☐ **Financial/Housing/Community Resource Needs:** _____

☐ **Pharmacy/Medication needs:** _____

☐ **Repetitive Use of ED Services/Multiple Hospitalizations:** _____

☐ **Social Concerns/Family Support:** _____

☐ **Transportation Needs:** _____