

Care Coordination/ Care Management Request Form

The Care Management Team at CHOC Health Alliance is comprised of Nurses, Social Workers, Physicians and Patient Care Coordinators who work to facilitate care coordination to our members and families. The team provides assessment, evaluation, planning, facilitation, and advocacy to promote the best possible outcomes for our members.

Please fax or email back along with clinical notes to:
Fax: (714) 628-9119 Email: CHACM@choc.org

Member Name: _____ **Date of Submission** _____

Birth Date: _____ **CIN#** _____ **Phone#:** _____

Requesting Provider: _____ **Phone#:** _____ **Fax#:** _____

Member's Diagnosis:

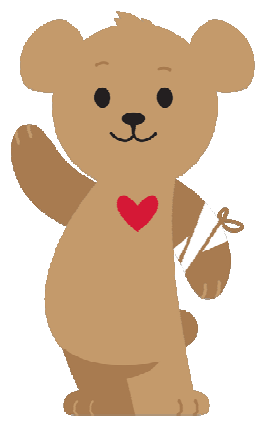
1. _____
2. _____
3. _____

Has the Caregiver/Patient been informed that a Care Management referral has been submitted: Yes _____ No _____

Caregiver/Parent name: _____ **Best contact phone/ email** _____

Please select the reason for referral to Care Management/ Care Coordination

- | | |
|---|--|
| <input type="checkbox"/> Chronic Illness/Complicated/Multiple Diagnosis | <input type="checkbox"/> Overwhelmed Family/Caregiver(s) |
| <input type="checkbox"/> High Utilization (High Inpatient/ED Use) | <input type="checkbox"/> Adherence Issues |
| <input type="checkbox"/> Behavior/Mental Health Issues/social issues | <input type="checkbox"/> Multiple Specialty/DME needs |
| <input type="checkbox"/> NICU Graduate | <input type="checkbox"/> Pregnancy |
| <input type="checkbox"/> Other _____ | |



Please complete this form for CHOC Health Alliance members only. We will review and assign Care Coordination at the level deemed appropriate.

Comments: _____

