**Community Care Coordination Referral Requests**

\*\* Referral requests must be filled out in their entirety and emailed to: [cmrequest@nvbhs.com](mailto:cmrequest@nvbhs.com)

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Member Information** | | | | | | | | | | | | | | | |
| **Request Date:** | | | |  | | | | | | |  | | | | |
|  | | | |  | | | | | | |  | | | | |
| **Member Name:** | | | |  | | | | | | | | |  | | |
|  | | | |  | | | | | | | | |  | | |
| **HPN ID#:** | | |  | | | | **Medicaid ID#:** | | |  | | **Gender:** |  | |
|  | | |  | |  |  | |
| **Homeless?** | | | Yes | | | No | | **Location:** | |  | | | | | |
|  | |  | | |  | | |  |  | | | | | |  |
| **If Not Homeless Current Address:** | | | | | | | |  | | | | | | | |
|  | | | | | | |  | | | | | | | | |
| **Phone #/Voicemail #:** | | | | |  | | | | | |  |  | | | |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **History/Medications** | | | | | | | |
|  | | | | | | | |
| **Psycho-Social Diagnosis:** |  | | | | | | |
| **Medical Diagnosis:** |  | | | | | | |
| **Current Psycho-Social Treatments** (if any)**:** |  | | | | | | |
| **Current Medical Treatments** (if any)**:** |  | | | | | | |
| **Psycho-Social History/SUD History:** |  | | | | | | |
| **Physical Health Medications:** |  | | | | | | |
| **Mental Health Medications:** |  | | | | | | |
| **Major Presenting Issues:** |  | | | | | | |
|  |  | | | | | | |
| **SUD Hx** (\*SOC & Route |  | | | | | | |
| of Administration)**:** |
| \*SOC – Substance of Choice | **Pregnant:** | Yes | No | **Trimester:** | First | Second | Third |
|  |  | | | | | | |
| **Type of Assistance Needed:** |  | | | | | | |

|  |  |  |  |
| --- | --- | --- | --- |
| **Referring Person’s Contact Information** | | | |
| **Name:**  **Phone:** |  | **Title:** |  |
|  | **Email:** |  |