**Community Care Coordination Referral Requests**

\*\* Referral requests must be filled out in their entirety and emailed to: 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:** |  |