# *Disease Management Referral Form*

All information contained on this form is strictly confidential and may become part of your patient's record.

| **Member's information** | |
|---|---|
| Member name: | Member DOB: |
| Member ID: | Gender: ☐Male ☐Female |
| Member phone: | Alternate phone: |
| Referring provider name: | Referral date: |
| Referring provider phone: | Referring provider fax: |

| **Health condition history** | |
|---|---|
| ☐ Asthma | ☐ HIV/AIDS |
| ☐ Bipolar disorder | ☐ Hypertension |
| ☐ Coronary artery disease | ☐ Major depressive disorder — adult<br>☐ Major depressive disorder — child/adolescent |
| ☐ Congestive heart failure | ☐ Substance use disorder |
| ☐ Chronic obstructive pulmonary disease | ☐ Schizophrenia |
| ☐ Diabetes<br>Insulin dependency? ☐ Yes ☐ No | |

| **Reason for referral** |
|---|
| |

| **Additional comments** |
|---|
| |

**Please fax form back to:**
**Disease Management**
**1-888-762-3199**