Care Coordination Referral Form

Columbia Pacific CCO™
Part of the CareOregon Family

Please fill out both pages with as much information as possible.
If you do not hear from us within 1 business day, please call 503-416-3731.

Referrer information

Referred By: _____ Contact phone #:_____
(Person completing this form preferred) (Direct number preferred)

Relation to member: _____ Agency/Role (If applicable): _____

If referrer is not the member, is the member aware of this referral? ☐ Yes ☐ No

Member name: _____

Date of birth: _____/_____/_____ Member ID: _____

Request for care coordination assistance for: *(Please check all that apply)*

- ☐ Provider access
- ☐ Complex medical condition(s)
- ☐ Behavioral Health support
- ☐ Self-management coaching and support
- ☐ Transition of care support
- ☐ Multiple admissions/readmissions
- ☐ Community-based resource support
- ☐ Substance use support
- ☐ Gender transition support
- ☐ Other (Describe) _____

Please provide details regarding the reason for referral/issues of concern:

Continued >>

Columbia Pacific CCO™
Part of the CareOregon Family

Care Coordination Referral Form

Member information

Member preferred name: _____

Pronouns: _____ Language: _____

Member phone/alternative contact: _____ Okay to leave voicemail? ☐ Yes ☐ No ☐ Unknown

Parent/guardian name and contact info (if applicable): _____

Preferred method of communication: ☐ Phone ☐ Text ☐ E-Mail _____ ☐ Unknown

DHS or I/DD caseworker? ☐ Yes ☐ No Phone: _____ Fax/E-mail: _____

What is member's current housing? ◯ Housed ◯ Temporary housing ◯ Homeless ◯ Unknown

Member physical address (please include the county the member lives in):

_____

Member mailing address (if different than above):

_____

Health plan:
◯ CareOregon Advantage ◯ OHP- Columbia Pacific (CPCCO) ID#: _____

Other health insurance: ☐ Yes ☐ No If yes, insurance carrier and ID#: _____

Native American/Alaskan Native: ☐ Yes ☐ No Tribal affiliation: _____

Member's PCP (if known): _____ Phone: _____

Mental health provider/agency (if known): _____ Phone: _____

If member is 17 or younger, please fill out the following if known/applicable:

Current school: _____ Grade: _____ School contact: _____

IEP? ☐ Yes ☐ No Phone: _____ Fax/Email: _____

Other supports/systems involved: _____

Phone: _____ Fax/Email: _____

Please send this form and any relevant chart notes or supporting documents by fax to: **503-416-3676** or secure e-mail to: *ccreferral@careoregon.org*