Care Coordination Referral Form

SCICN-VC Care Coordination
Office: 805.256.1380
Fax: 805.256.1378
Email: carecoordination@identitymso.com

Date of referral: _____

Referring source: _____

PATIENT INFORMATION

Patient's last name: _____

First: _____

Middle: _____

Birthdate: _____

Age: _____

Sex: [ ] Male [ ] Female

Primary contact phone number: _____

Secondary contact phone number: _____

Contact name (if other than patient): _____

Relationship to patient: _____

Primary language: _____

PCP: _____

Referred by & contact number: _____

Diagnosis: _____

Care coordination needs / reason for referral: _____

Priority status of referral: [ ] Urgent [ ] Standard/Routine

Patient notified of referral: _____

Patient agrees to participate: _____

PLEASE ATTACH:

- **Patient demographic sheet**
- **Last chart note**
- **Medication list**

Fax or email completed referral/intake form and the items listed above to: 805.256.1378 or carecoordination@identitymso.com

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CARE COORDINATION USE ONLY

Received in office: _____

Date recorded on flow sheet: _____

Outreach date: _____

Outreach date: _____

Outreach date: _____

Outreach letter sent & date: _____

Care coordinator: _____

Initial assessment appt. date & time: _____

Clinical Integration Care Coordination Provided by identityMSO

Southern California Integrated Care Network
Ventura County Chapter