STATE OF OKLAHOMA

SOONERCARE

Population Care Management Referral Form

Population Care Management Phone **1-877-252-6002**	**Population Care Management Fax** **405-530-3217**

Referral Date:		**Date PCM Referral Received:**	
		Received by:	
		Referral Source Notified of Receipt: ☐ **Yes**	

Referral Information

Referral Source:

☐ Primary Care Provider
☐ Specialty Provider
☐ ER Department
☐ Caseworker/DC Planner
☐ Community Agency
☐ Transition Coordinator
☐ Other (define:) _____

Referral Name: _____ **Referral Phone (Direct line preferred):** _____

Member Information

Member Name: _____ Member ID: _____

Member DOB: _____ Member Phone: _____

Contact Name: _____ Contact Phone: _____

Relationship to Member: ☐ Self ☐ Family ☐ Other (specify) _____

Reason for Referral (Check all that apply)

Chronic and Complex Care Support

☐ Member has chronic condition and is at risk for poor outcome (Diabetes, Asthma, CAD, Hypertension, Hemophilia, Sickle Cell Anemia, Other) Please circle applicable conditions

☐ Member is overweight and desires support in losing weight

☐ Member uses tobacco and desires support in tobacco cessation

☐ Member has multiple inpatient admissions

☐ Member has complex discharge needs

☐ Member is child with special health care needs; require assistance with care

☐ Member needs education regarding condition

☐ Other Chronic Care concerns (specify) _____

Utilization Management / Acute Care Support

☐ Member is pregnant and is at risk for poor outcome

☐ Member has had multiple ER visits

☐ Member has Poly-pharmacy issues

☐ Member may need access to Out of State Care

☐ Member has education needs related to benefits

☐ Member needs access to community resources

☐ Member needs access to specialty services

☐ Member needs Living Choice Assessment

☐ Other concerns (specify)_____

Please describe your concerns and reason for referral / desired outcome: