Care Coordination Referral Form

To be eligible for services, individual must have Medicaid and their Physician must be contracted with the ACHN

1445 S. College Street, Suite 300
Auburn, AL 36832

For questions, please call: 334-466-4610
Toll Free: 1-833-296-5246
Fax: (334) 466-4609

Name: _____ Guardian Name (if applicable): _____

Medicaid ID: _____ DOB: _____

Physical Address: _____ Phone Numbers: _____

Please attach a current medication list and demographic information.

Type of Referral:

- ☐ **Family Planning**
- ☐ **General Care Coordination**
- ☐ **Maternity**

Hospital Referral? ☐ Yes ☐ No Discharge Date: _____

Provider Referral? ☐ Yes ☐ No Last Visit Date: _____

Referring Provider Name: _____

Reason for General Care Coordination Referral:

- ☐ Non Compliance:
  - ☐ Clinic Visits ☐ Medication ☐ Other _____
- ☐ Medication Education
- ☐ Inappropriate ED Utilizations
- ☐ Frequent Hospitalizations
- ☐ Diagnosis Education
  Diagnosis: _____ ☐ Newly Diagnosed ☐ If Diabetic, A1C Level: _____
  Date Obtained: _____
- ☐ Patient needs behavioral health follow-up:
  - ☐ Psychiatry ☐ Substance Abuse ☐ Counseling
- ☐ Transportation
- ☐ Other: _____

Additional Comments:

_____

_____

Referral Source Contact Person: _____ **Phone:** _____ **Fax:** _____

Referring Agency: _____ **Date of Referral:** _____

Please fax completed form to: (334) 466-4609