Florida Health Care Plans®

An Independent Licensee of the Blue Cross and Blue Shield Association

Case Management Coordination of Care Referral

Referral Source: ______________________ Ext: __________
(Name)

Patient Name: __________ Med Rec #: ______ PCP: __________

Patient Address: ______________________

Patient Phone Number: __________ Cardiologist __________

Reason for Referral: ______________________

Relevant Diagnosis – all that apply (✓)

- ☐ Diabetes I or II
- ☐ COPD/Asthma
- ☐ CAD
- ☐ ESRD
- ☐ PVD
- ☐ CHF (NYHA Class)
- ☐ Others (list) __________

Risk Factors

- ☐ Hx. Falls
- ☐ Lives Alone
- ☐ Confused
- ☐ Not Aware of Dx
- ☐ Other __________
- ☐ Medication Compliance
- ☐ HTN
- ☐ Afib
- ☐ Hyperlipidemia
- ☐ Mental Health Dx.
- ☐ Other __________

Recent Hospitalization and/ or ER visit within the past 6 months:

__________ __________ __________

__________ __________ __________

If applicable, please include pertinent clinical records with referral:

- ☐ H & P
- ☐ Most recent specialist dictation (i.e. Cardiology, Pulmonology, Oncology, Nephrology, etc.)
- ☐ EF %, Echogram, Cardiac Catheterization dictation, etc.
- ☐ Medication List

- ☐ Any additional information ______________________

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Completed by: ______________________ **Date:** __________

Send to:
Case Management Coordination of Care
1510 Ridgewood Avenue,
Holly Hill, Florida 32117
Phone: 386-238-3284
Toll Free: 855-205-7293
Fax: 386-238-3271
cmanagement@fhcp.com