



**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 _____

Completed by: _____ Date: _____

Send to:

Case Management Coordination of Care

1340 Ridgewood Avenue,

Holly Hill, Florida 32117

Phone: 386-238-3284

Toll Free: 855-205-7293

Fax: 386-238-3271

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