

## CLINICAL PROGRAMS REFERRAL FORM

Referral Date:

### MEMBER INFORMATION

Member Name:	Date of Birth:
Member ID #:	Best Contact Phone Number(s):
Preferred Language:	Preferred Pronoun(s):
Parent/Guardian/Caregiver (if applicable):	Is member aware of this referral?    Yes    No

### PROVIDER INFORMATION

Provider Name:	Role in member's care team    PCP    Specialist
Office Contact Name:	Contact email:
Contact Phone #:	Contact Fax #:
Follow up preference:    Call    Email    Fax	Best time to call back:

CURRENT MEDICAL CONDITION(s)	REASON(S) FOR REFERRAL
Asthma Congestive Heart Failure COPD Diabetes:    Type 1    Type 2    Gestational Disability:    Developmental    Intellectual Physical Other (Please specify): Elevated Lead Level Epilepsy/seizures Hepatitis C Hypertension Kidney Disease	Assist with locating specialty provider <b>Assist with identifying community resources:</b> Financial Food Legal Assistance Utility Assistance Baby Partners- Perinatal CM Program Estimated delivery date: Behavioral Health/Crisis follow up (recent suicide attempt or bereavement support) Caregiver Resources DME-Unmet needs Fitness benefit information Gaps in Care Maternal Home Visiting (Parental Support Program) Medication non-adherence Nutritional counseling Postpartum Home Visit Psychosocial supports- lack of Transportation- lack of reliable transportation Other (please describe):

### ADDITIONAL INFORMATION

Please send the completed form to:  
 Email: [ClinicalConnections@jeffersonhealthplans.com](mailto:ClinicalConnections@jeffersonhealthplans.com) or  
 Fax: 215-845-4181 For additional assistance or to follow-up on your referral  
 please call: Clinical Programs Provider Referral Line - 215-845-4797