CAPITALcare
COLLABORATIVE

CCC Case Management Referral Form – UNINSURED PATIENTS
For Wake County Residents Only

Please fax this form to Keith Ward at **919-723-9385**

Date: _____ Referral Source/Agency: _____

Patient name: _____ Male Female **(circle one)**

DOB: _____ Phone#: _____

Physical Address: _____

Person referring: _____ (MD, RN, SW, Other) **please circle**

Phone#: _____ Fax#: _____

Reason(s) for Referral: (check all that apply)

____ **Repetitive use of Emergency Department (2 or more visits in the last 6 months)**

____ No PCP/PCH

____ Mental Health Concerns: _____

____ Social concerns/Family support (please specify): _____

_____

___ Financial/Housing/Community Resource Needs (please specify): _____

_____

___ Transportation needs

___ Chronic/Complex Medical Condition (please specify): _____

_____

___Chronic Pain Concerns (specify):_____

_____

___ Needs assistance in following plan of care for chronic illnesses (please specify): _____

_____

_____

Call KEITH WARD/PATIENT NAVIGATOR with questions: 919-792-3676