



116 WASHINGTON AVENUE, 2<sup>ND</sup> FLOOR, NORTH HAVEN, CT 06473 800-925-3606 203-239-7444 FAX: 203-239-5308

## MEMBER OUTREACH REQUEST FORM

This form is to be used for active *Preferred One* members only.

### REFERRAL SOURCE INFORMATION:

Date:	Person Making Referral:	Title:
Address:		City:
State:	Zip:	Phone:

### PATIENT INFORMATION

Patient Name:		DOB:	Member ID:	
Head of Household/Guardian:			Phone:	
Address:		City:	State:	Zip:
State:	Zip:			Phone:
English Speaking: Yes No Unknown		If No, Language Spoken:		
Patient's PCP:		PCP Phone:	PCP ID:	

### REASON FOR REQUEST (CHECK ALL THAT APPLY)

<input type="checkbox"/> Managed Care/Preferred One	<input type="checkbox"/> Missed appointments
<input type="checkbox"/> Inappropriate Emergency Room use	<input type="checkbox"/> Behind on EPSDT
<input type="checkbox"/> Needs to select new PCP	<input type="checkbox"/> Health management issues
<input type="checkbox"/> Unable to contact after repeated attempts	<input type="checkbox"/> Patient behavior
<input type="checkbox"/> Translating	<input type="checkbox"/> Other (please comment below)
Immediate Care Needed: Yes <input type="checkbox"/> No <input type="checkbox"/>	

### PATIENT PROFILE

<input type="checkbox"/> Pregnancy	<input type="checkbox"/> Asthma	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Behavioral health issues
<input type="checkbox"/> Cancer	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Lead Poisoning	<input type="checkbox"/> Other

### COMMENTS



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