Care Management Referral Form

Cullman, Limestone, Madison, Morgan, Marshall, and Jackson Counties

Form must be completely filled out in order to be processed

Recipient Name: ____ Date: ______________________

DOB: ______________________ Sex __________ Recipient / Guardian Phone:____________________

Medicaid #: ___________________________ Primary Language: ______________________________

Home Address (include city and zip): ____

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Emergency Contact: __________________________________ Phone: _________________________

Referring Physician / Facility: ____

Contact Name: _____________________________ Phone/Email:______________________________

Medical Diagnoses (Not required to make a referral):

Asthma
BMI greater than 25
Cancer
COPD
Diabetes
Heart Disease
Hepatitis C
HIV
Mental Illness
Organ Transplant
Sickle Cell
Substance Disorder

Other ____

Reason for Referral

Behavioral Health
Community Resources
Health/Disease Education
Housing
Informatics/Quality Measures
Maternity Services
Medication Management
NET Transportation Assistance
Substance Abuse Services

Other ____

Special Instructions / Pertinent Information

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Send referral form to:
Fax: (256) 382-2715
Email: referrals@northalcc.org