Case Coordination / Management Referral Form
UCare Fax: 612-884-2066

Product:		
Patient Information		
Patient Name:	Date of Birth:	UCare ID#:
Mailing Address:	County:	Phone:
Member speaks: ☐ English ☐ Burmese ☐ Hmong ☐ Karen ☐ Spanish ☐ Somali ☐ Russian ☐ Other:		Interpreter Needed: ☐ Yes ☐ No
Referral Source		
Name of person referring:		Phone:
Clinic/County/Organization:	Do you want to be contacted regarding this referral? ☐ Yes ☐ No	
Provider Information (if known)		
Primary Care Provider/Title:		Phone/Fax:
Primary Care Clinic:		
Case Manager/County Worker:		Phone/Fax:
Other Specialist/Clinic:		Phone/Fax:
Power Of Attorney / Authorized Representative / Parent:		Phone:
Relationship to Patient:		Consent Form Needed? ☐ Yes ☐ No ☐ Unknown
Reason for Referral		
Reason for Referral/Diagnosis:		

*Attach any supporting documentation that maybe helpful in processing this referral for case management.

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