



Referral to Population Health Management Team

Referral Line Phone: 1-866-534-4638

Fax: 860-812-2209

Referral Source Name: _____

Phone: _____

Date of Referral: _____

I. Patient Demographic Information:

Name: _____ DOB: _____

Patient Contact #: _____ PCP: _____

Responsible Contact: _____ Phone: _____
(if applicable)

Is the patient or responsible contact aware of the referral? Yes No

II. General Area of Support Requested:

- Care Coordination** (assistance making appointments, acquiring medical, transportation, Caregiver Support, etc.)
- Social Determinants of Health** (concerns regarding access to food, housing, clothing, utilities, financial assistance, insurance needs, coordination of community resources, etc.)
- High-Risk Pharmacy** (medication optimization, improving med adherence, polypharmacy/deprescribing, finding affordable medications)

- Pre-Disease/Disease Management** (smoking cessation, BMI>30, prediabetes, new diagnosis of a chronic condition or at risk for disease progression i.e. diabetes, HTN, CHF)
- Complex Care** (polychronic, high utilization, goals of care, advanced CHF/COPD)
- Behavioral Health** (positive depression screening, substance abuse, coordination of psychiatric services)

III. Specific Concerns:

IV. Priority:

High (within 1-3 business days) Moderate (within business 4-7 days) Low (within 1-2 weeks)