OHSU Health Services

Case Management Referral

Member Name: ____ Date: ________________

DOB: _______________ Member OHP ID: _______________ Phone number: ____________________

Gender Identification: _________________________________ Pronoun: _______________________

What language does the member prefer? ☐ English ☐ Spanish ☐ Other: __________________________

Is the member independent or dependent with their ADLs? ☐ Independent ☐ Dependent ☐ Unknown

Does the member have a caregiver, caseworker at APD, DHS, or another agency? ☐ Yes ☐ No ☐ Unknown

Name: _________________ Agency: _____________________ Phone number: ___________________

Name: _________________ Agency: _____________________ Phone number: ___________________

Name: _________________ Agency: _____________________ Phone number: ___________________

Referring Provider/Clinic/CBO: ____

Contact Person: _______________________________________ Phone Number: ___________________

Is the member aware of referral? ☐ Yes ☐ No

If not, explain: ____

Please provide information regarding referral/member concerns:

Please secure email this form and relevant chart notes to ohsuhscareteam@ohsu.edu

Member Services: 844-827-6572 / www.ohsu.edu/health-services