Community Health Hub Referral

Please FAX referral to: **503-857-0767**

Questions? Contact Member Engagement Supervisor at 503-455-8052.

Use this form if you have a patient who needs additional support. Please give a detailed description of the individual's need.

INDIVIDUAL BEING REFERRED

Name:_____ DOB:_____

Phone #:_____ YCCO/Medicaid ID #: _____

Physical address:_____ Language: _____

REASON(S) FOR REFERRAL

Does the member know about this referral? ☐ **YES** ☐ **NO**

Please provide as much information as possible so that your referral can be assigned to the appropriate resource.

- ☐ Frequent ED visits
- ☐ No PCP engagement
- ☐ Dental/ Vision Health need
- ☐ Complex health issues
- ☐ Transportation assistance
- ☐ Lack of support system (crisis management, socialization)
- ☐ Chronic disease management
- ☐ Weight or nutrition management
- ☐ Needs Multi-Disciplinary Team discussion
- ☐ CHW/Peer Support

Additional information:

PERSON MAKING THE REFERRAL

Date of Referral:_____ **Your Name:** _____

Name ofClinic/Hospital/Organization: _____

Contact Phone #:_____ **Contact Email:** _____