Sickle Cell Disease Referral Form

Provide the following information for the sickle cell patient to be referred. Please inform the patient they will be contacted by CCNC to assist with the arrangement of additional resources if needed.

Date of Referral from ED:	
Patient Last Name:	
Patient First Name:	
Best contact info for patient: 2nd contact	Name: #: Name #:
Patient DOB:	
Patient Medicaid ID:	
Patient County of Residence	
Referring ED:	
Referring Provider, Credentials, contact	
Patient is aware of referral	□ yes □ no
Primary Care Provider, if known	
Sickle Cell Specialist, if known	
Care Plan Attached	Yes or No General plan Pain specific plan
List Specific Reason for Referral (CHECK ALL THE APPLY)	☐ Emotional ☐ Financial (Insurance, bills) ☐ Medical (Needs PCP) ☐ Prescriptions ☐ Relational Issues/Family Support System ☐ Transportation □ Pain Management Additional Comments :
Please fax completed form to:	CCNC Call Center: 888.978.0645
Form Completed By / Date:	