Wyoming Department of Health

WYhealth

WYhealth Care Management Referral Form

Client/patient information:

Name: _____ DOB: _____ Medicaid #: _____ Address: _____

City: _____, WY Zip: _____ Phone Number(s): (h)_____(c) _____

Parent/Guardian: _____ Phone Number: _____

Primary language: ☐English ☐ Spanish ☐Other: _____ Primary Diagnosis: _____

Reason for referral (check all that apply):

☐ Education RE: dx/treatment plan ☐Medication/treatment compliance ☐Smoking cessation ☐Links to community resources
☐Assist coordination of care ☐Disease management* ☐Adult weight management ☐Depression
☐Mental health/psychosocial concerns ☐High risk maternity: weeks gestation _____ ☐Recent hospitalization/readmission
☐Other: _____
Helpful documents to attach if available: current medications list, history & physical, psychosocial assessment, recent progress note
**Asthma, Diabetes, CAD, COPD or HF*

Do you want the Case Manager to contact you with patient care updates? ☐No ☐Yes, if yes, please provide name, title, phone number and/or email address to use for provider communication purposes. _____
_____

Facility/provider information: ☐PCP ☐Psychiatrist ☐RN/LPN ☐LCSW/LPC ☐Other: _____

Referring provider: _____ Address: _____

City: _____ State: _____ Zip: _____ Email: _____

Phone: _____ Fax: _____

Additional providers for patient (if applicable):

PCP: _____ Mental health: _____

Other: _____

Fax completed form to 1-888-245-1928. For questions, please call WYhealth at 1-888-545-1710
All cases will be reviewed for determination and eligibility.