GULF COAST
Regional Care Organization
Administered by:
VIVA HEALTH

Region E Health Home
Referral Form

PATIENT INFORMATION

Date of Referral: _____

Patient Name: (Last)_____ (First)_____ (MI)_____

Medicaid Number: _____ Date of Birth: _____ Gender: ☐M ☐F
(Note: Must be a Patient 1st patient)

Primary Phone Number: ( ) _____ Other Number: ( ) _____

Emergency Contact: _____ Contact Phone: ( ) _____

Physical Address: _____

_____

QUALIFYING CONDITIONS: *(Please check all chronic conditions that apply. Note: Patient must be diagnosed with at least one of the following to be eligible for services)*

☐ Asthma ☐ Cancer ☐ Heart Disease ☐ Sickle Cell ☐ Mental Illness

☐ COPD ☐ Diabetes ☐ Transplant ☐ HIV ☐ Substance Abuse

☐ BMI Over 25 ☐ Hepatitis C

Reasons for Referral: *(Please indicate the reason for referral to Region E Health Home and any special instructions or considerations needed)*

_____

_____

_____

REFERRAL SOURCE INFORMATION

Referral Source: _____ Phone: ( ) _____ Fax: ( ) _____

Are you the patient's designated PMP? ☐Yes ☐No

Facility Contact: _____ Facility Email: _____

Referral made by: _____ _____
(Contact Name) **(Title)**

Please FAX all referral forms to (251) 476-5155 or email to VIVAReferRegE@uabmc.ed

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