**Optum Idaho Field Care Coordination Referral Form**

Date:
Organization/Provider:
Name of Person making referral:
Best person to contact regarding this referral(if different than above):
Relationship to Member:
Phone: Email address:

Mbr notified of referral: Yes No

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Member Name:
Member ID:
BH Diagnoses :
Region where member lives: ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7
Member's and/or Guardian's Contact Information:

Reason for Referral:

Identified Risk Factors:

Number of inpatient admissions in the past 12 months:

Is Member impacted by any of the following? (Check all that apply) :

☐Child Protection ☐Hospitalizations ☐Coordinaton of Care Concerns
☐Children's Mental Health ☐Probation/Legal ☐Developmental Disabilities
☐Special Education/IEP ☐Medication Concerns ☐ Substance Abuse
☐Suicide Risk ☐Disengagement from treatment
☐Lack of natural support ☐ Medical conditions
☐ Current Outpatient Commitment
☐ Other (Please describe)_____________________________________________________

Please submit referrals to:
Email: Optum.idaho.fcc@optum.com
Fax # 888-891-1232