

## HealthPartners Programs Referral Form

<b>Member Name:</b>		<b>Date of Last HRA:</b>	
<b>Member ID:</b>		<b>Member Phone Number</b>	
<b>CC Name:</b>		<b>CC Phone Number:</b>	
<b>Best Time to Reach Member:</b>			

### What program are you referring to?

<input type="checkbox"/> Medical Disease or Condition Management		Complete STEPS 1 & 2 <i>(skip step 3)</i>
<input type="checkbox"/> Rare and Chronic Disease Management		Complete STEP 3 only <i>(skip steps 1 and 2)</i>
<input type="checkbox"/> RRP, Behavioral Health, Tobacco Cessation, Weight Loss, MTM		Complete STEP 3 only <i>(skip steps 1 and 2)</i>

### STEP 1: DESCRIBE SITUATION THAT NEEDS TO BE ADDRESSED

*Please complete the following when a member is needing education on a specific health condition*

**Describe the specific health condition or question that requires education.**

**Describe member knowledge and deficiencies regarding condition. Include adherence to treatment plan.**

**List Primary Care Provider.**  
*Include Physician Name, Clinic, and Phone Number.*

**List Specialty Provider related to condition.**  
*Include Physician Name, Clinic, and Phone Number.*

**List up-coming medical appointments.**  
*Please list specify provider and include dates.*

**Have there been any recent hospitalizations or ER visits related to this health condition?**

*If yes, Please Describe.*

**What educational materials/reference sheets has the CC provided to member?**

*Please see HealthPartners Health information Library*

**Additional Comments**

**STEP 2: EMAIL THIS FORM TO SNBC CARE COORDINATION EMAIL**

*This tool is used by internal staff to prepare for educational conversation with member.*

Email this completed form to [HPSNBC\\_CC@healthpartners.com](mailto:HPSNBC_CC@healthpartners.com)  
to open Outlook with PDF automatically attached.

**STEP 3: COMPLETE ONLINE REFERRAL FORM**

*This referral form ensures that referral is routed to the correct team.*

This will open online referral form.