Click or tap below to enter a date.

Date of Referral:

Source of referral: Health Plan Case Manager

STAT REFERRAL (specify reason below) ROUTINE REFERRAL

Member Name:		DOB:	
Health Plan Choose one		Member ID:	
Address:			
City:	State:	Zip:	County
Facility (if applicable):		Facility Phone (if applicable):	
Member Primary Phone Number:		Member Email:	
Member Cell Phone Number:		Member Consent to Text: Yes No	
MPOA/Caregiver Name: *Please provide copy of paperwork*		MPOA/Caregiver Phone:	
Case Manager/Resource Name:		Case Manager/Resource Phone:	
		Case Manager/Resource Email:	
Did Member consent to Referral/Aware of Services: Yes No			
Does Member have a MOLST?: Yes No			

Prior/Current PCP Name:	Prior/Current PCP Phone:
Reason for Referral / Current Services:	
Known Barriers (for example, physical barriers to accessing the home, language barriers, cognitive barriers, member does not follow doctor's orders, etc.):	
If STAT Referral, please provide reason below:	
Notes to Lucet At Home Team (Any other information the Team should know, include specific details as appropriate):	

Please email the complete referral form to referrals@lucethealth.com