Advanced Health
289 LaClair St, Coos Bay, OR 97420
Voice: 541-269-7400 • 800-264-0014
Fax: 541-269-7147 • TTY: 877-769-7400

Special Needs Referral Form

Date: ____/____/____

Member Name: _____ Member ID #: _____

Date of Birth: ____/____/____

Presenting situation or problem (if any):

Diagnosis:

☐ Amputation ☐ Eating Disorder ☐ Massive Physical Trauma ☐ Transplant

☐ Cerebral Palsy ☐ ESRD/Dialysis ☐ Prematurity

☐ Congenital Abnormality ☐ HIV ☐ Spina Bifida

☐ Other Diagnosis with high service utilization, please list/describe:

☐ Challenging behavior issues, please list/describe (i.e. drug seeking, non-compliant):

Phase II:

☐ Aged (65 years old or older)

☐ Blind ☐ Disabled/MRDD

Additional Comments or Concerns:

Name of Reporting Party: _____

Department/Agency: _____

Phone Number: _____