Care coordination request

InterCommunity Health Network CCO

As a new member, you may have concerns or questions about your ongoing care needs. Please complete all parts below that apply to you. Return the form as soon as you can.

Care Coordination at IHN-CCO
PO Box 1310
Corvallis, OR 97339

Fax: 541-768-9768

Member information

Name:	Date of birth:
Member ID:	Phone:
Preferred name:	Preferred pronouns:
Doctor:	Doctor phone:

Are you:

Getting treatment for any conditions or trauma now? ❑ Yes ❑ No
If yes, please describe: _____

Scheduled for surgery or a stay in the hospital during the next 90 days? ❑ Yes ❑ No
If yes, please describe: _____

Getting chemotherapy, radiation therapy or other cancer therapy? ❑ Yes ❑ No

Enrolled in home care or hospice? ❑ Yes ❑ No

A candidate for organ transplant? ❑ Yes ❑ No

Getting treatment as a result of a recent major surgery? ❑ Yes ❑ No

Enrolled in a program now that teaches you how to manage disease ? ❑ Yes ❑ No
If yes, please describe: _____

Pregnant now? ❑ Yes ❑ No
If yes, when is the due date? _____

Using a specialty pharmacy now? ❑ Yes ❑ No
If so, please write the names of the pharmacy, the drug and the doctor who prescribed it.

_____

Do you need help with food, housing or transport? ❑ Yes ❑ No
If yes, please explain: _____

List the names of prescribed drugs you routinely take (you don't need to list any over-the-counter or herbal drugs). For each, include the name and phone of the prescribing doctor:

Drug name	**Prescribing doctor**	**Phone**

Please describe the condition and/or treatment plan for which you request help:

Signature

I understand that, by signing this form, I agree to enroll in the Care Coordination Program and will be contacted by IHN-CCO staff to help me. I acknowledge that my involvement is voluntary.

Name:	Date: