

MEMBER INFORMATION		REFERRAL DATE:	
<b>SoonerCare Choice:</b> <input type="checkbox"/> Yes (Continue to HAN for Referral) <b>SoonerSelect Aetna Better Health of OK</b> <input type="checkbox"/> Yes (Continue to HAN for Referral) <input type="checkbox"/> <b>NO (STOP – Refer to Clinic for Internal Care Management)</b>		<b>Member ID (9 Digit RID #):</b>	
<b>Member's Name:</b>		<b>Date of Birth:</b>	
<b>Mailing Address:</b>	<b>Physical/Finding Address (if different):</b>	<input type="checkbox"/> <b>Cell Phone #:</b>	
<b>Email Address:</b>		<input type="checkbox"/> <b>Home/Other Phone #:</b>	
<b>Additional Contact Name: (If Applicable)</b>	<input type="checkbox"/> Parent <input type="checkbox"/> Primary Caregiver <input type="checkbox"/> Legal Guardian** <input type="checkbox"/> POA** <input type="checkbox"/> Other _____	<input type="checkbox"/> <b>Phone #:</b>	
CLINIC INFORMATION			
<b>Clinic Name:</b>		<b>Primary Care Provider:</b>	
<b>Person Making Referral</b>	Name:	<b>Clinic Primary Contact</b> (If different than person making referral)	Name:
	Phone #:		Phone #:
<b>Primary Diagnosis:</b>		<b>Language Request for Care Management:</b>	
<b>Secondary Diagnosis:</b>		<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other: _____	
<b>Reason for Referral (Check all that apply and provide details in comment section):</b> <input type="checkbox"/> Poorly controlled chronic condition(s) <input type="checkbox"/> Multiple unmet complex social needs <input type="checkbox"/> Behavioral Health <input type="checkbox"/> High ER Utilization <input type="checkbox"/> Frequent missed appointments for chronic condition(s) <input type="checkbox"/> Other: Required comments:			
<b>Does Member know about referral?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No, if no why not?			
<b>Date of Member's Last PCP Appointment:</b>		<b>Date of Member's Next PCP Appointment:</b>	
FOLLOW UP - Please indicate preferred follow up method:			
<input type="checkbox"/> <b>Secure Email to Clinic Care Manager Contact:</b>		<input type="checkbox"/> <b>Secure Email to PCP and Clinic Care Manager Contact:</b>	
_____		_____	
<input type="checkbox"/> <b>Secure Email to PCP:</b>		<input type="checkbox"/> <b>Phone report:</b> _____	
_____		<input type="checkbox"/> <b>Scanned report</b> <input type="checkbox"/> <b>Other:</b> _____	
<input type="checkbox"/> <b>Please attach an updated medication list and any pertinent medical records to this referral.</b>			

**SOONER HAN INTERNAL USE ONLY**

<b>Referral Review Completed by:</b>	<b>Date:</b>
<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>Assigned to:</b> _____	
<input type="checkbox"/> <b>No – Returned to Clinic</b> <input type="checkbox"/> <b>Complex Care Management needs not identified</b> <input type="checkbox"/> <b>Not SoonerCare Choice Eligible</b>	

**DIRECTIONS TO SUBMIT REFERRAL**

Please Submit Referral to the Sooner HAN, one of the following two ways:

Fax: (918) 660-3042 OR;  
Email: [SoonerHAN@ouhsc.edu](mailto:SoonerHAN@ouhsc.edu) (Secure Email Only.)

**\*\*Legal Guardian and/or POA – Must provide copy of Legal Guardianship and/or POA Documents**