Health Partners Plans Confidential Referral for Services

For HPP use only (required): ☐ Medicaid New ☐ Medicaid Additional Round

Name *(First, MI, Last)*: ______________________ **Date of Birth:** __________

Street Address: ______________________ **Unit Number** *(if needed)*: ______

City: __________ **State:** ______ **Zip Code:** ______ **Phone:** __________

Alt. Phone: __________ **Email:** __________ **Veteran?** ☐ Yes ☐ No

Gender: ☐ Male ☐ Female **Ethnicity:** ☐ Hispanic ☐ Non-Hispanic

Race *(please check all that apply)*: ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other: __________

Language: ☐ English ☐ Spanish ☐ Other: __________

Emergency Contact Name: __________ **Emergency Contact Phone:** __________

HPP Member ID: __________

Primary Diagnosis: __________ **ICD Code:** ______ **Date of Diagnosis:** ______

Secondary Diagnosis: __________ **ICD Code:** ______ **Date of Diagnosis:** ______

Food Allergies? ☐ Yes ☐ No Describe: __________

Treatment Plan/Member Goal: __________

Coexisting Conditions: __________

Recent Hospitalizations/ER Visits *(Dates/Reasons)*: __________

Current Height: ______ **Current Weight:** ______ **Date Weighed:** ______

Weight History *(including dates)*: __________

Significant Lab Values *(if available)*:

Test	Albumin	CD4	Chol.	Glucose	HbAlc	Hgb.	Kidney or Liver Tests	TG
Value								
Date *Month/Year*								

Current Medications or Supplements: __________

____

Ambulation or Living Environment Concerns: __________

Provider Name: __________ **Phone:** __________

Email: __________ **Fax:** __________

Please email form to clinicalconnections@hpplans.com.
For any questions, call HPP at 215-845-4797.

****Confidential Facsimile ****

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