Health Partners Plans

Clinical Programs Referral	
Referral Information	**Patient Information**
Referring Provider Name & Specialty:	*Patient Name:* *DOB:* *HPP ID#:*
Referring Provider Contact (Phone/Email):	*Caregiver's Name (if applicable):*
Hospital/Clinic Name:	*Phone:*
Date of Referral:	*Preferred Language:* *Preferred Pronoun:*
Provider Appointment Information	
Date member last seen in office:	*Date of next office appointment:*

Past Medical History:

☐ Diabetes
- ☐Type 1
- ☐Type 2

☐ Congestive Heart Failure
☐ Asthma
☐ COPD
☐ Hypertension
☐ Kidney Disease
☐ Epilepsy/Seizures
☐ Hepatitis C
☐ Other (please describe below)

Height:_____ Weight: _____

Identified Needs for Care Coordination

☐ Medication non-adherence
☐ Transportation needs
☐ Nutritional counseling
☐ Fitness benefit information
☐ Behavioral Health concerns
☐ Psychosocial determinants
- ☐ Unstable housing /Homelessness
- ☐ Financial difficulties
- ☐ Food insecurity

☐ Health literacy/disease education (describe)
☐ Lack of psychosocial supports
☐ Other (please describe below)

Additional information:

Please send the completed form to:
Email: ClinicalConnections@hpplans.com or Fax: 215-845-4181

For additional assistance or to follow-up on your referral please call:
HPP Clinical Programs Provider Referral Line - 215-845-4797