Multidisciplinary team referral form

eocco
EASTERN OREGON COORDINATED CARE ORGANIZATION

This referral form is for difficult cases that require additional input and resources. It's designed for the EOCCO supervisor, case management, as well as Aging and People with Disabilities (APD) to collaborate and meet the needs of complex EOCCO members.

Section 1 Member information

Last name	First name	Middle initial	County of residence
Date of referral (mm/dd/yyyy)	ID/Prime #		Date of birth (mm/dd/yyyy)

Section 2 Current state of health

Does member currently have any of these resources, to your knowledge?	APD services ☐ Yes ☐ No GOBHI — mental health ☐ Yes ☐ No EOCCO case management ☐ Yes ☐ No	Known barriers to care
Current diagnosis/issue		
Pertinent history		

Section 3 What services are you seeking?

Physical health	
Mental health	
Is member aware of referral? ☐ Yes ☐ No	Phone # of member
Person completing this form	Phone # of referring person for questions *(Required for ICM referrals)*

Ready to submit?

Residents of Baker, Harney, Grant, Malheur, Union and Wallowa counties, please email completed form to:
East6MDT@modahealth.com

Residents of Morrow and Umatilla counties, please email completed form to:
UMMDT@modahealth.com

Gilliam, Wheeler, Sherman and Lake counties, please email completed form to:
West4MDT@modahealth.com

Questions? Please call 1-844-827-7467 for assistance

eocco.com

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