



# CONSULTATION REQUEST

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## Care Management Services

To: GRIPA Intake Staff  
Fax: 585-922-1524  
Phone: 585-922-1520

Date \_\_\_\_\_

From (Provider) \_\_\_\_\_

Office Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Insurance Plan: (please circle) Preferred Care WellCare

Contract #: (if available) \_\_\_\_\_

Program requested: (please circle)

Diabetes Geriatrics Pharmacy Depression Case Management

**Please attach the following:**

- **Current Diagnosis/Medication list** including over the counter medications, vitamins, supplements, herbs.
- **Copies of your progress notes** from the last 6-12 months.
- **Copies of letters sent by consultants** from the last 6-12 months.
- Other pertinent psychosocial information that would be helpful.

If you are unable to provide this information, we would be glad to complete a chart review in your office.

**Thank you for this referral. We look forward to working with you.**

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health care could look like this

**Greater Rochester Independent Practice Association**

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