Eastern Oregon Coordinated Care Organization (EOCCO) offers telephonic health management services, through the Personal Health Management program, to members who: **have EOCCO, are 18 years old and up, speak any language, and are identified with 1 or more of the behavioral/medical conditions listed below**. Health management assists members diagnosed with chronic conditions to improve their quality of life through a strengths-based approach.

Health management interventions focus on:
- Condition-specific education related to self-management and lifestyle change
- Navigation of the healthcare system & identification of resources
- Improved self-advocacy
- Coordination of Care between the member and their practitioners
- Strengthening of support systems related to each member's healthcare goals
- Building a roadway to overcome barriers that inhibit successful condition management

A referral into Personal Health Management supports your patients who are:
- Non-adherent to the treatment regimen (medication or therapy) prescribed by their treating practitioners
- Have experienced a recent acute, sub-acute or emergency room event
- Are in need of condition-specific individual, family or caretaker consultation, education and advocacy
- High utilization of healthcare services

You can refer a member directly by completing the referral detail below & faxing this form to the secure fax line: Fax to: 1-888-708-0684
Attn: Kiley Broe, Dania Feller Anderson

Please mark an "X" by all applicable diagnoses

Asthma	_____	Crohn's Disease	_____	Multiple Sclerosis	_____
Chronic Back Pain	_____	Depression	_____	Obesity	_____
Chronic Kidney Disease	_____	Diabetes	_____	Osteoarthritis	_____
Congestive Heart Failure	_____	Epilepsy/Seizures	_____	Parkinson's Disease	_____
COPD	_____	Hypertension	_____	Rheumatoid Arthritis	_____
Coronary Artery Disease	_____	Migraines	_____	Ulcerative Colitis	_____

Referral Source (required)

Name: ______________________ Department/Title: ______________________

Date Referred: ______________________ Contact Phone/Ext: ______________________

Member/Patient Information (required)

Name: ______________________ Member ID: ______________________

Address: ______________________ City/State/Zip: ______________________

DOB: ______________________ Phone #(s): ______________________

Next Scheduled Office Visit: ______________________ Language Spoken: ______________________

Additional Comments: ____

____