Case Management

Referral form

*Member's full name:	*DOB:
Member's preferred phone number:	
*Your name:	
*Your contact information:	
*Date of referral:	

** Required fields*

Indicate the desired program(s) to which you would like to refer this member.
☑ Check all boxes that apply.

❑ **Behavioral Health**	❑ Two or more hospitalizations and/or ER visits for behavioral health conditions within the previous 12 months ❑ Has depression and has needs related to: • Education about the condition and/or • Advocacy and help accessing behavioral health providers ❑ Has anxiety and has needs related to: • Education about the condition and/or • Advocacy and help accessing behavioral health providers ❑ Has a chronic condition and needs coordination (Describe in Comments section.)
❑ **Care coordination**	❑ Assistance understanding health plan benefits ❑ Assistance with transportation to medical appointments utilizing Plan benefits or community resources ❑ Assistance with obtaining DME, understanding Plan network and coordination needs
❑ **Chronic condition programs**	❑ Two or more hospitalizations and/or ER visits for asthma, COPD, diabetes or cardiac conditions within the previous 12 months
❑ **Complex needs**	❑ Examples are: recent functional changes, special health needs in children, active treatment for oncology patients, burns, ALS, MS, brain injury, paralysis, multiple traumatic injuries, chronic major psychiatric illness or a general health rating of fair to poor (Describe in Comments section.)
❑ **Memory specialist**	❑ Dementia or Alzheimer's diagnosed ❑ Need for advanced planning ❑ Need for member/family/caregiver education on the disease progression and community resources
❑ **Oncology**	❑ Two or more hospitalizations and/or ER visits for oncology concerns within the previous 12 months ❑ Presence of metastatic disease and multiple providers involved requiring care coordination and member case management support

Indicate the desired program(s) to which you would like to refer this member. **☑ Check all boxes that apply.**	
❑ **Palliative care**	❑ Presence of disease (acute or chronic life threatening or limiting conditions)
❑ **Pharmacy review**	❑ Polypharmacy: more than 8 Rx (Attach medication list.) ❑ High cost (more than $4,000 annually) ❑ Potential drug regimen adverse reactions/interactions (Describe below.)
❑ **Pregnancy** Last menstrual period: _____ Estimated due date: _____	❑ History of preterm delivery (less than 37 weeks) ❑ History or current PTL, PROM, abnormal bleeding, cerclage ❑ History or current PIH, preeclampsia, hyperemesis ❑ History of low birth weight infant (less than 2500 grams or 5 lbs., 8 oz.) ❑ Chronic health condition, i.e. diabetes or other chronic health condition ❑ Recent emergency room visit/hospitalization ❑ New pregnancy or fetal complication (Describe below.) ❑ Previous and/or current behavioral health issues affecting pregnancy ❑ Previous and/or current substance abuse affecting pregnancy ❑ Socioeconomic concerns–unmet basic needs such as food, housing or transportation ❑ Unsafe living environment such as homelessness, violence or abuse
❑ **Renal**	❑ ESRD, newly diagnosed ❑ ESRD, receiving dialysis
❑ **Social care management**	❑ Socio-economic concerns ❑ Community resources ❑ Long-term care placement (Describe below.) ❑ Legal concerns (Describe below.) ❑ Financial issues pertaining to Rx cost (Describe below.) ❑ Other (Describe below.)
Comments:	

Thank you for your referral!

Please fax this completed form to Clinical Integration at 1-508-368-9030.
If you have any questions, please call the Clinical Integration Department at
1-508-799-2100, ext. 78002, Monday through Friday from 8:30 a.m. to 5:00 p.m.