



CARE COORDINATION REFERRAL SCREEN

Original Referral Contact: _____

Location: _____

Phone: _____

Person filling out form: _____ Date of Referral: _____

- | | |
|---------------------------|----------------------|
| 1. Member Name: _____ | 7. ID#: _____ |
| 2. DOB: _____ | 8. PCP/Clinic: _____ |
| 3. Address: _____ | 9. PCP Phone: _____ |
| 4. Phone: _____ | 10. Pharmacy: _____ |
| 5. Language Spoken: _____ | 11. Veteran: _____ |
| 6. Cultural Needs: _____ | 12. Email: _____ |

REFERRAL REASONS (Check all that apply)

Medical Needs

- | | |
|---|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> DME/Specialty Care |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Pain Management | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Hep C/Liver Disease | <input type="checkbox"/> Currently Pregnant |
| <input type="checkbox"/> Cardiac/Vascular Conditions | <input type="checkbox"/> Disability or Intellectual Delay |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Neurological Conditions or Stroke |
| <input type="checkbox"/> Asthma/Breathing Problems/COPD | <input type="checkbox"/> Medication Management |
| <input type="checkbox"/> Deaf, Blind, Hearing Problems, Vision Impairment | <input type="checkbox"/> Other/Specific Details: |
| <input type="checkbox"/> Bladder or Kidney Problems | |
| <input type="checkbox"/> Orthopedic Condition | |
| <input type="checkbox"/> Dermatology/Skin Conditions | |

Families with Children

- | | |
|--|--|
| <input type="checkbox"/> 1. Child with DHS involvement | <input type="checkbox"/> 5. Grandparents with dependent children |
| <input type="checkbox"/> 2. Child at risk of first episode psychosis | <input type="checkbox"/> 6. Guardians of children |
| <input type="checkbox"/> 3. Children (0-5) at risk of maltreatment or showing early signs of behavioral problems | <input type="checkbox"/> 7. Children with Neonatal Abstinence Syndrome |
| <input type="checkbox"/> 4. Parents with dependent children | |

Behavioral Health/Substance Use Needs

- 1. IV or Opioid drug use
- 2. Mental Illness or Behavioral health condition
 - Therapy needs/access to mental health provider needs
 - Other:

- 3. Enrolled in MAT program

Social Determinants

- 1. Recent Homelessness: _____
- 2. Needs adequate housing/safety/utilities: _____
- 3. Caregiving Needs: _____
- 4. Nutrition / Food Access Needs: _____
- 5. Medication or Medical equipment / Access Needs: _____
- 6. Dental Access Needs: _____
- 7. Communication Needs: _____

Coordination (Other) needs

- | | |
|---|--|
| <input type="checkbox"/> 1. Transportation Needs | <input type="checkbox"/> 4. 2+ Hospital visits in the last 6 months (including ED or admission) |
| <input type="checkbox"/> 2. Recent hospitalization (within 30 days) – refer to Transition of Care Nurse. | <input type="checkbox"/> 5. Two or more placements in the last 6 months (ex. Adult or Child Foster Home, LTC facility) |
| <input type="checkbox"/> 3. Receiving Long Term Care (LTC), Long-Term Services and Support (LTSS) OR APD Services through the Dept of Health and Human Service <ul style="list-style-type: none">a. If applicable, LTS/LTSS/APD case worker name:
_____ | <input type="checkbox"/> 6. Needing assistance with Treatment Plan |

Referral / Eligibility

1. If they have been hospitalized in the last 30 days, the member is eligible for Transitions of Care (TOC)
2. If a **BOLDED** item is checked, or member has two or more chronic conditions, they are eligible for intensive Care Coordination (ICC)
3. Does the member want to discuss participation in any case management / care coordination services?
Yes No
4. If referring source is not a contracted provider/agency with Advanced Health, an ROI should be included.
5. Please attach at least 2 medical notes, if applicable and Treatment Plan/Assessment/Discharge Summary
6. Additional information relevant to care coordination needs:

ICC Referral Instructions:

1. Email completed form to ICCreferals@advancedhealth.com or
2. Fax completed form to 541-269-2052