



REFERRAL SCREENING FOR ADVANCED HEALTH CM / ICC

Original Referral Contact:

Location:

Phone:

Person filling out form: _____ Date of Referral: _____

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

REFERRAL REASONS (Check all that apply)

Medical Needs

- | | |
|--|---|
| <input type="checkbox"/> 1. Diabetes | <input type="checkbox"/> 10. Tuberculosis |
| <input type="checkbox"/> 2. Cancer | <input type="checkbox"/> 11. HIV/AIDS |
| <input type="checkbox"/> 3. Pain Management | <input type="checkbox"/> 12. Currently Pregnant |
| <input type="checkbox"/> 4. Hep C/Liver Disease | <input type="checkbox"/> 13. Disability or Intellectual Delay |
| <input type="checkbox"/> 5. Heart Conditions | <input type="checkbox"/> 14. Stroke |
| <input type="checkbox"/> 6. High Blood Pressure | <input type="checkbox"/> 15. Medication Management |
| <input type="checkbox"/> 7. Asthma/Breathing Problems/COPD | <input type="checkbox"/> 16. Denied Authorizations |
| <input type="checkbox"/> 8. Deaf, Blind, Hearing Problems, Vision Impairment | <input type="checkbox"/> 17. Other: |
| <input type="checkbox"/> 9. Bladder or Kidney Problems | |

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

- 1. Transportation Needs**
- 2. Recent hospitalization (within 30 days) – refer to Transition of Care Nurse.**
- 3. Receiving Long Term Care (LTC) or Long-Term Services and Support (LTSS) through the Dept of Health and Human Service**
- 4. 2+ Hospital visits in the last 6 months (including ED or admission)**
- 5. Two or more placements in the last 6 months (ex. Adult or Child Foster Home, LTC facility)**
- 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