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: _____
12. Email: _____

REFERRAL REASONS (Check all that apply)

Medical Needs

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

Families with Children

1. ☐ **Child with DHS involvement**
2. ☐ **Child at risk of first episode psychosis**
3. ☐ **Children (0-5) at risk of maltreatment or showing early signs of behavioral problems**
4. ☐ **Parents with dependent children**
5. ☐ **Grandparents with dependent children**
6. ☐ **Guardians of children**
7. ☐ **Children with Neonatal Abstinence Syndrome**

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), Long-Term Services and Support (LTSS) OR APD Services through the Dept of Health and Human Service**
  - a. **If applicable, LTS/LTSS/APD case worker name:**

    _____
- ☐ 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 ☐
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 ICCreferrals@advancedhealth.com or
2. Fax completed for to 541-269-2052