CASE MANAGEMENT REFERRAL REQUEST

Fax authorization request to: (818)534-5423

DATE SUBMITTED: ________________

CASE MANAGEMENT REFERRAL CRITERIA MET (Select one)

☐ **Patient with 2 or more medical conditions listed below AND 1 High Risk Criteria below**
☐ **Patient with 1 poorly controlled medical conditions below AND 2 High Risk Criteria below**

PLEASE INCLUDE ALL RECENT PROGRESS NOTES, MEDICATIONS, PERTINENT LABS AND IMAGING STUDIES.

Patient Name	Male ☐ Female ☐	DOB	Age
Address	City		Zip
Phone No:	Member Number & Health Plan		
Family/Caregiver Name	Relationship	Phone	
PCP Name	Contact/Completed by:	Phone	

MEDICAL CONDITIONS

Must have 2 or more of these Medical Conditions AND 1 High Risk criteria OR 1 of these Medical Conditions with 2 High Risk Criteria)

☐ CHF (Stage 3+4 /C+D) or Ejection Fraction <35%)
☐ COPD w/all of the following: O2 Dependent, on Steroids & Inhaler, Restricted ADLs & multiple ER visits in 6 mo period
☐ CVA with stroke prevention therapy
☐ Dementia w/comorbidities and Dependent for ADLs.
☐ Diabetes Uncontrolled or HA1C > 12
☐ End Stage Aids
☐ Multiple Wound Ulcers
☐ New onset of paralysis, paraplegia or Quadriplegia (diagnosed within 90 days)

HIGH RISK CRITERIA

****Must have 1 High Risk criteria w/ 2 or more Medical Conditions above or 2 High Risk criteria with at least 1 Medical Condition above)**

☐ Poor Social Support (please provide explanation below)

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☐ Poor Functional Status (please provide explanation below)

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☐ Poor Nutritional Status (please provide explanation below)

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☐ > Non-Compliance (Defined as: patient having multiple PCP visits once every month for 6 month period and member continues to be non-compliant). Please provide all PCP office visit dates below.

Visit 1 ________ Visit 2 ________ Visit 3 ________ Visit 4 ________ Visit 5 ________ Visit 6 ________

☐ > 2 Hospitalizations or > 3 ER visits in previous 6 months