



## outpatient care services referral form

Member's full name\*: \_\_\_\_\_ Date of referral (mm/dd/yyyy)\*: \_\_\_\_\_

Member's FCHP ID Number\*: \_\_\_\_\_ DOB (mm/dd/yyyy)\*: \_\_\_\_\_

PCP's name and location (please print)\*: \_\_\_\_\_

Has PCP approved member's participation\*?  Yes  No

Your name (if not member's PCP), title and contact information\*: \_\_\_\_\_

### ***\*Required Fields***

Please indicate our desired outpatient care services program(s) and related referral criteria which you would like to refer this member to. Please add any additional comments below.

- Respiratory**
  - Hospital admission and/or ER visit for asthma/COPD within the previous 12 months
  - History of premature beta agonist refills or concern with medication compliance
- Cardiac**
  - A cardiac event (MI, CABG, PCTA) and/or unstable angina within the previous 12 months
  - Hospital admission and/or ER visit for CHF within the previous 12 months
- Diabetes**
  - HbA1c > 8.5 or HbA1c <8.5 with multiple co-morbidities
  - Hospital admission and/or ER visit within previous 12 months
- Pregnancy**
  - History or current PTL, PROM, abnormal bleeding, cerclage
  - History or current PIH, preclampsia, hyperemesis
  - Chronic health condition i.e. diabetes
  - Socioeconomic concerns
- Palliative Care**  Presence of significant Disease (end stage and/or chronic), Victoria Hospice Society Palliative Performance Assessment Scale (PPS) @ 50% or less, and/or Pain Management Issues  $\geq$  5 per Universal Pain Assessment Tool
- Transplants**
  - Currently awaiting transplant
  - Transplant completed < 1 year ago Type: \_\_\_\_\_
- Social Service**
  - Financial Assessment  Long Term Care Placement (Describe Needs Below)
  - Community Resources  Legal Concerns (Describe Needs Below)
- Pharmacy Review**
  - Poly Pharmacy >10 Rx (Attach medication list)
  - High Cost (>\$1,500 yearly)/Financial Issues pertaining to Rx (Describe Below)
  - Potential adverse medication reactions (Describe Needs Below)
- Complex Needs** Examples are children with special health needs, oncology, burns, ALS, MS, brain injury, paralysis, multiple traumatic injuries, chronic major psychiatric illness or general health rated fair to poor (Describe in detail below)

Comments: \_\_\_\_\_

Thank you for your referral! Please **fax** the completed form to **508-368-9711**. For questions, please contact Outpatient Care Services at 508-368-9301 or 508-368- 9920. For additional copies of this form, please visit [www.fchp.org/Providers/Forms](http://www.fchp.org/Providers/Forms).