

Disease Management - Case Management 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 the desired Disease Management or Case Management services program(s) and related referral criteria to which you would like to refer this member. Please add any additional comments below.

- | | |
|---|---|
| <input type="checkbox"/> Respiratory | <input type="checkbox"/> Hospital admission and/or ER visit for asthma within the previous 12 months |
| | <input type="checkbox"/> History of premature beta agonist refills or concern with medication adherence |
| <input type="checkbox"/> Cardiac | <input type="checkbox"/> A cardiac event (MI, CABG, PCTA) and/or unstable angina or heart failure diagnosis within the previous 12 months |
| | <input type="checkbox"/> Hospital admission and/or ER visit for cardiac disease or heart failure within the previous 12 months |
| | <input type="checkbox"/> Comorbidities |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> HbA1c greater than 8.0 and less than 8.9 |
| | <input type="checkbox"/> HbA1c greater than 9 |
| | <input type="checkbox"/> Hospital admission and/or ER visit for diabetes within the previous 12 months |
| <input type="checkbox"/> Pregnancy | <input type="checkbox"/> History or current PTL, PROM, abnormal bleeding, cerclage |
| | <input type="checkbox"/> History or current PIH, preeclampsia, hyperemesis |
| | <input type="checkbox"/> Chronic health condition, i.e. diabetes |
| | <input type="checkbox"/> Socioeconomic concerns |
| <input type="checkbox"/> Palliative care | <input type="checkbox"/> Presence of disease (acute or chronic life threatening or limiting conditions) |
| <input type="checkbox"/> Transplants | <input type="checkbox"/> Request submitted for transplant evaluation |
| | <input type="checkbox"/> Currently awaiting transplant |
| | <input type="checkbox"/> Transplant completed less than 1 year ago Type: _____ |
| <input type="checkbox"/> Renal | <input type="checkbox"/> ESRD, newly diagnosed |
| | <input type="checkbox"/> ESRD, receiving dialysis |
| <input type="checkbox"/> Social service | <input type="checkbox"/> Financial assessment |
| | <input type="checkbox"/> Long-term care placement (Describe below.) |
| | <input type="checkbox"/> Community resources |
| | <input type="checkbox"/> Legal concerns (Describe below.) |
| <input type="checkbox"/> Pharmacy review | <input type="checkbox"/> Polypharmacy: more than 10 Rx (Attach medication list.) |
| | <input type="checkbox"/> High cost (more than \$1,500 yearly)/Financial issues pertaining to Rx (Describe below.) |
| | <input type="checkbox"/> Potential adverse medication reactions (Describe below.) |
| <input type="checkbox"/> Complex needs: | Examples are special health needs in children, active treatment for oncology patients, burns, ALS, MS, brain injury, paralysis, multiple traumatic injuries, chronic major psychiatric illness or a general health rating of fair to poor (describe in detail below). |

Comments: _____

Thank you for your referral! Please fax the completed form to 1-508-368-9878. For questions, please contact the Case Management Department at 1-508-368-9577 or 1-508-368-9935. For additional copies of this form, please visit fchp.org/providers/forms.