MediGold

Case Management Referral Form

Our plan provides telephonic case management services to our members to assist with coordinating services, short-term intensive intervention or long-term education and monitoring. The goal is to facilitate maximum functional levels at the most appropriate intensity of service. If you identify one of our members at risk for high utilization of service or needs assistance in coordinating health care services, please complete this form.

Submit completed form via fax to: 1-614-234-7195 or CaseManagement@MediGold.com.

First Name	**Last Name**	**Member ID**

Date of Birth	**Phone Number**	**Discharge Date**

☐ **Recent hospitalization or surgery**

Reason(s) for referral: (Check all that apply)

☐ Multiple Medical Diagnosis:

- ☐ CHF
- ☐ COPD/Pulmonary disorders
- ☐ Pneumonia
- ☐ Falls/Fractures/Osteo/RA
- ☐ Diabetes/Metabolic/Endocrine
- ☐ Cancer
- ☐ Hypertension Coronary artery disease/HLD
- ☐ Kidney/ESRD
- ☐ Dementia/Alzheimers
- ☐ Chronic pain
- ☐ Neurological disorders
- ☐ Other

☐ Behavioral Health Issues:

- ☐ Depression
- ☐ Anxiety
- ☐ OCD
- ☐ PTSD
- ☐ Bi-Polar
- ☐ Schizophrenia
- ☐ Aggressive behavior
- ☐ Suicidal
- ☐ Substance abuse
- ☐ Other

☐ Social Issues:

- ☐ Family neglect
- ☐ Financial
- ☐ Housing/Environment/Living arrangements
- ☐ Lack of basic needs
- ☐ Lack of social support (caregiver)
- ☐ Assistance with daily living concerns

☐ Frequent ED or inpatient admissions.

☐ Non-adherent with medical or prescription recommendations.

☐ Other Please provide: _____

Physician Name	**Physician Phone Number**

Person Submitting Referral	**Date**