

Case Management Referral Form

Health Plan

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:

- | | |
|---|---|
| <input type="checkbox"/> CHF | <input type="checkbox"/> Hypertension Coronary artery disease/HLD |
| <input type="checkbox"/> COPD/Pulmonary disorders | <input type="checkbox"/> Kidney/ESRD |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Dementia/Alzheimers |
| <input type="checkbox"/> Falls/Fractures/Osteo/RA | <input type="checkbox"/> Chronic pain |
| <input type="checkbox"/> Diabetes/Metabolic/Endocrine | <input type="checkbox"/> Neurological disorders |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Other |

Behavioral Health Issues:

- | | |
|-------------------------------------|--|
| <input type="checkbox"/> Depression | <input type="checkbox"/> Schizophrenia |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Aggressive behavior |
| <input type="checkbox"/> OCD | <input type="checkbox"/> Suicidal |
| <input type="checkbox"/> PTSD | <input type="checkbox"/> Substance abuse |
| <input type="checkbox"/> Bi-Polar | <input type="checkbox"/> Other |

Social Issues:

- | | |
|--|--|
| <input type="checkbox"/> Family neglect | <input type="checkbox"/> Lack of basic needs |
| <input type="checkbox"/> Financial | <input type="checkbox"/> Lack of social support (caregiver) |
| <input type="checkbox"/> Housing/Environment/Living arrangements | <input type="checkbox"/> 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

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