



# External Care Management Referral Form

ACC/DDD/RBHA LOB: email form to [AcuteCMReferral@mercycares.org](mailto:AcuteCMReferral@mercycares.org)

DCS CHP LOB: email form to [MCPDCSCHPCMRReferral@AETNA.com](mailto:MCPDCSCHPCMRReferral@AETNA.com)

MCA LOB: email form to [MCACMRReferral@mercycares.org](mailto:MCACMRReferral@mercycares.org)

### INDIVIDUAL SENDING THE REFERRAL

Referred by:	Referral Source:	Date:
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### MEMBER INFORMATION

Member Name:	Member DOB:
Member A#:	Current Tel. #
CHP ID#:	Current CHP ID Tel. #
Current address:	
Facility Name/Type:	
Primary Line of Business:	

### DIAGNOSIS (List)

Behavioral Diagnosis:	
Medical Diagnosis:	
Current PH/BH Provider(s):	

### PURPOSE OF REFERRAL (Mark all that apply)

At Risk Institute of Mental Disease (IMD): (Explain)	
Special Health Care Needs (SHCN):	
Financial Concerns/Benefits Needed: (Explain)	
Discharge Barriers: (Explain)	
Disease or Chronic Condition Unmanaged: (Explain)	
Domestic Violence/Abuse: (Explain) Adult Protective Services (APS) report filed?	
Alcohol (ETOH) / Drug Abuse / Medication-Assisted Treatment (MAT)/Opiate Use Disorder (OUD): (Explain)	
Durable Medical Equipment - DME Needed:	
Arizona Long Term Care (ALTCS) / Assertive Community Treatment (ACT) Referral needed:	
Frequent Emergency Room (ER) Visits: (How many over (x) months)	
Hearing/Vision (Deaf/Blind):	
High Risk Pregnancy (Refer all DCS members) Neonatal Intensive Care Unit (NICU) >30 days:      NAS:	
Complex Social Determinants of Health Needs:	
Left Against Medical Advice + Readmission <30 days:	
Medication Non-compliance:	
Department of Child Safety Comprehensive Health Plan (DCS/CHP): Triage for stratification to appropriate LOC:	
Other: (Explain)	

Comments and/or clinical information to support information above: