

## External Care Management Referral Form

### INDIVIDUAL SENDING THE REFERRAL

Referred by:	Referral Source: *Select from drop down	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:	Select LOB	Language:

### DIAGNOSIS (List)

<input type="checkbox"/> Behavioral Diagnosis:	
<input type="checkbox"/> Medical Diagnosis:	
<input type="checkbox"/> Current PH/BH Provider(s):	

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

<input type="checkbox"/> At Risk Institute of Mental Disease (IMD): (Explain)	
<input type="checkbox"/> Special Health Care Needs (SHCN):	Choose an item.
<input type="checkbox"/> Financial Concerns/Benefits Needed: (Explain)	
<input type="checkbox"/> Discharge Barriers: (Explain)	
<input type="checkbox"/> Disease or Chronic Condition Unmanaged: (Explain)	Choose an item.
<input type="checkbox"/> Domestic Violence/Abuse: (Explain) Adult	
<input type="checkbox"/> Protective Services (APS) report filed?	
<input type="checkbox"/> Alcohol (ETOH) / Drug Abuse / Medication-Assisted Treatment (MAT)/Opiate Use Disorder (OUD): (Explain)	
<input type="checkbox"/> Durable Medical Equipment - DME Needed:	
<input type="checkbox"/> Arizona Long Term Care (ALTCS) / Assertive Community Treatment (ACT) Referral needed:	
<input type="checkbox"/> Frequent Emergency Room (ER) Visits: (How many over (x) months)	
<input type="checkbox"/> Hearing/Vision (Deaf/Blind):	
<input type="checkbox"/> High Risk Pregnancy (Refer all DCS members)	
<input type="checkbox"/> Neonatal Intensive Care Unit (NICU) >30 days:      NAS: <input type="checkbox"/>	
<input type="checkbox"/> Complex Social Determinants of Health Needs:	Choose an item.
<input type="checkbox"/> Left Against Medical Advice + Readmission <30 days:	
<input type="checkbox"/> Medication Non-adherence:	
<input type="checkbox"/> Department of Child Safety Comprehensive Health Plan (DCS/CHP): Triage for stratification to appropriate LOC:	
<input type="checkbox"/> Other: (Explain)	
Veteran: Yes <input type="radio"/> No <input type="radio"/>	

Comments and/or clinical information to support information above: