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| --- | --- | --- | --- | --- | --- |
| Member Name | | Click or tap to enter a date. | | Referral # | |
| Health Plan/LOB | | Referred by | | Contact number of referrer | |
| Member Number | | Member Phone | |  | |
| **Choose Program Type – check Program type and items that apply for member** | | | | | |
| **Episodic Care Management**  Requires less than 60 days of care | **Complex CM (CCM)**  Requires greater than 60 days of care. For member with 5 or more inclusion criteria | | **Disease Management**  **CHF  COPD** | | **Social Worker -** Social/behavioral needs only |
| **Long term Care Management**  May require more than 60 days of care | **Med Management –**  High risk/high cost medication prescribed. Episodic Care | | **Transition of Care -**  Intervention focused on member that is transitioning across levels of care | | **Care Coordination –**  Assistance with appointments, DME |
| **Inclusion criteria** | | | | | |
| 2 or more active chronic diagnoses; CHF, COPD, ESRD, CKD 4-5, CRF, Oncology with metastasis (excluding breast, prostate or thyroid) | Sudden disability such as; transplant, burns, trauma, spinal cord injury | | 2 or more unplanned admissions/6 months | | Assistance in obtaining community resources |
| Sudden catastrophic diagnosis such as ALS, Guillain-Barre, surgical oncology, traumatic brain injury | Four or more daily medications | | 2 or more ED visits/6 months | | Home environment evaluation for potential ADL deficits |
| History of non-adherence with plan of care | Referred by PCP for assessment and coordination of care | | 2 or more 911 calls/ 6 months | | Patients who have reached the prescription coverage gap (donut hole) |
| Caregiver issues | Receiving ongoing care at tertiary care/OON providers | | 3 or more DME items | | Loss of spouse |
| Placement Issues | Unstable living situation | | 2 or more behavioral health admits/6 months | | Financial distress |
| **Diagnoses** | | | | | |
| Diagnosis ICD 10 | | Diagnosis ICD 10 | | Diagnosis ICD 10 | |

**Please fax completed form to:  
Care Management Department (951) 280-8203**

**For Questions Regarding Referrals, call the Ambulatory Care Management Team at (951) 280-7819**