mercy care

External DCS CHP Care Management Referral Form

INDIVIDUAL SENDING THE REFERRAL					
Referred by:		Department:		Date:	

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:	Department of Child Safety Comprehensive Health Plan (DCS/CHP)		

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):	
	Arizona Long Term Care (ALTCS) / Assertive Community Treatment (ACT) Referral needed:	
☐	Discharge Barriers: (Explain)	
☐	Disease or Chronic Condition Unmanaged: (Explain)	
☐	Domestic Violence/Abuse: (Explain)	
☐	Adult Protective Services (APS) report filed?	
☐	Durable Medical Equipment - DME Needed: List	
	Alcohol (ETOH) / Drug Abuse / Medication-Assisted Treatment (MAT)/ Opiate Use Disorder (OUD): (Explain)	
☐	Financial Concerns/Benefits Needed: (Explain)	
☐	Frequent Emergency Room (ER) Visits: (How many in/months, hospital visits)	
☐	Hearing/Vision (Deaf/Blind):	
☐	High Risk Pregnancy	
☐	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: