mercy care

Submit by E-Mail to
AcuteCMReferral@mercycareaz.org

External ACC Care Management Referral Form

INDIVIDUAL SENDING THE REFERRAL					
Referred by:		Department:		Date:	

MEMBER INFORMATION			
Member Name:		Member DOB:	
Member A#:		Current Tel. #	
Current address:			
Facility Name/Type:			
Primary Line of Business:	Choose an item		

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):	Choose an item
☐ Arizona Long Term Care (ALTCS) / Assertive Community Treatment (ACT) Referral needed:	
☐ Discharge Barriers: (Explain)	
☐ Disease or Chronic Condition Unmanaged: (Explain)	Choose an item
☐ 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:	Choose an item
☐ 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: