



mercy care

External MCA Care Management Referral Form

INDIVIDUAL SENDING THE REFERRAL

Referred by:	Department:	Date:
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MEMBER INFORMATION

Member Name:	Member DOB:
Member A#:	Current Tel. #
Current address:	
Facility Name/Type:	
Primary Line of Business:	Mercy Care Advantage

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

Comments and/or clinical information to support information above: