Case Management Referral Form

PLEASE FAX TO (805) 681-8260

Questions? Call us at (805) 562-1082, Option #2

Date: _____

MEMBER INFORMATION:

Last Name: _____ First Name: _____

Member ID#: _____ Date of Birth: _____

Address: _____

Phone Number: _____ Preferred Language _____

REFERRAL SOURCE INFORMATION:

Referring physician last name: _____ Physician first name: _____

Phone Number: _____ Fax Number: _____

REFERRAL REASON(S):

_____

_____

CLINICAL INFORMATION (Include ED/ inpatient stays and other agencies involved, i.e; home health, IHSS, CCS, TCRC, etc.)

_____

_____

_____

Is the member or primary caregiver aware that a case management referral was made?

☐ YES ☐ NO

Name of person completing form (please print):_____

Phone #: _____Fax #: _____

Thank You for the Referral!

See the **CenCal HEALTH** *Webpage* for the online referral: **https://www.cencalhealth.org/**

Go to the [Providers] Tab and select the [Case Management Referral Form]

Submitting a Case Management Referral

Please fax the following to CenCal's Case Management Department at 805-681-8260

Completed Referral Form

1. **Any additional clinical information** that may help the case manager address the needs of the member

Case Management – General Information
CenCal's case management services are provided by registered nurses, social workers, and transitional care coordinators. They help members who:

- have a complex medical or behavioral health conditions
- have high psychosocial risk factors
- need assistance navigating through the health care system and continuum of care

Upon referral, a Case Manager will screen for appropriateness and triage for the urgency of initiating CM services. If the member accepts Case Management, the Case Manager will formulate a Plan of Care and inform the member's PCP. If the member declines Case Management, the Case Manager will notify the referral source.

Examples of Cases that Should Be Referred to Case Management Services:

- Medical non-adherence (e.g., two or more missed appointments, misuse of medications, poor dietary adherence)
- High utilization of ED visits (e.g., two visits in three months)
- Members who over/under utilize medical services that are available to them
- Frequent hospital admissions (same or different diagnosis) and readmissions (within 30 days of discharge) for ambulatory care sensitive conditions such as diabetes, asthma, congestive heart failure, hypertension (e.g., four hospital admissions in one year)
- Psychosocial high risk factors resulting in significant negative health outcomes
- Cognitive changes as evidenced by significant fluctuations in memory, mood, personality or behavior by the geriatric client
- Fragile condition with comorbidities requiring assistance with implementing a treatment plan and addressing access barriers
- Coordination of care is needed for members receiving medically necessary services outside of the Health Plan's provider network.
- Unstable medical conditions warranting closer monitoring (e.g., uncontrolled diabetes, exacerbating asthma, COPD, CHF)
- Complex or chronic medical condition, including those which affect multiple organ systems and/or which require ongoing complicated therapy (e.g. transplants, cancer, ESRD,COPD, CHF, uncontrolled diabetes, terminal illness without hospice services)
- Require assistance following a particular medical regime (e.g., pre-surgical)
- Self-care deficits requiring one-to-one or group health education to promote well-being
- Care coordination with specialized programs, such as Local Education Agency, Regional Centers, or CCS