



**CASE MANAGEMENT REFERRAL FORM**

<b>To: El Paso Health</b> <b>ATTN: Case Management</b> Phone: (915) 532-3778 ext. 1500 <b>Fax: 915-298-7866</b>	FROM: _____ <b>(Physician's Office Name)</b> OFFICE CONTACT PERSON: _____ FAX NUMBER: _____ TELEPHONE NUMBER: _____
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<b>Member Name:</b>	<b>Medicaid/CHIP ID #:</b>	<b>DOB:</b>
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<b>Member Contact Number:</b>	<b>Member Address:</b>
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**REASON FOR REFERRAL (check all that apply and add comments when applicable):**

<input type="checkbox"/> <b>HIGH RISK PREGNANCY</b>
<input type="checkbox"/> <b>BEHAVIORAL HEALTH</b>
<input type="checkbox"/> <b>ASTHMA</b>
<input type="checkbox"/> <b>HEART DISEASE</b>
<input type="checkbox"/> <b>DIABETES</b>
<input type="checkbox"/> <b>SPECIAL HEALTH CARE NEEDS</b> (individuals who have a behavioral/medical condition that is expected to last more than 12 months)
<input type="checkbox"/> <b>SOCIAL WORK</b>
<input type="checkbox"/> <b>OBESITY</b>

**PRESENTING CONCERN:**

- Assistance locating covered services
- Coordination of care
- Non-compliance with treatment plan
- Assistance obtaining durable medical equipment/medical supplies (i.e. nebulizer, peak flow meter)
- Patient education (i.e. symptom management, self-management strategies, diabetes education)
- Assistance accessing treatment for behavioral health diagnosis
- Social concerns, please specify concern(s): \_\_\_\_\_
- High risk pregnancy, please specify condition/concern: \_\_\_\_\_
- Access to community resources (i.e. support/advocacy groups, basic needs)