Home Care referral event

Date: _____/_____/_____ **Recommended program** (Click link to access vendor referral email below)**:**

☐ Palliative Care ☐ Heal ☐ Partners In Care Foundation (PICF) ☐ Personal Care Services

Referral information

Referral Title: ☐ CM Nurse ☐ UM Nurse ☐ Other: _____

First name	Last name	MI
Phone number	Contact Name (If different from Referring Person)	Email (of referring contact)

Member information

Last name	First name	MI	Gender ☐M ☐F
Date of birth (mm/dd/yyyy)_____/____/_____ Age	Member ID		CAC#
Street address		City	
County		State	Zip Code
Home phone	Cell phone		
Service facility (If applicable)	Bus Phone		

Member consent (if applicable): ☐ Yes ☐ No	**Preferred language:** ☐ English ☐ Spanish ☐ Chinese ☐ Vietnamese ☐ Korean ☐ Other: **English fluency:** Member: ☐ High ☐ Medium ☐ Low ☐ No fluency Caregiver/family member: ☐ High ☐ Medium ☐ Low ☐ No fluency	Power of Attorney? (POA) ☐ Yes ☐ No

Care Giver / Alternate contact information (If no Caregiver, enter "None"; if POA is **Yes**, enter Medical Decision Maker info)

Name	Relationship
Cell phone number	Preferred phone number

Primary Care Physician information

Name			NPI
Street address			City
State	Zip Code	Bus Phone	Fax number

BSC requesting (Check the appropriate box that applies to ANY home care referral)

☐ **1) Home Visit (Indicate Vendor Program Above)**
- ☐ Post-Discharge (All LOBs)
- ☐ All Other (All LOBs)

☐ **2) Evidence-Based Self-Management Program**

☐ **3) Onsite Facility Visit (In-patient at the facilities listed below)**
- ☐ UCLA Ronald Reagan
- ☐ UCLA Santa Monica
- ☐ Other

Expected Discharge Date: _____

Room #: _____

Blue Shield Concurrent Review RN

Name: _____

Phone: _____

Email: _____

☐ **4) Palliative Care/Other (Vendor Name):**

_____

Diagnosis Criteria (Check all that apply)
- ☐ Chronic Illness: CHF, DM, COPD
- ☐ Acute Illness – Pneumonia, MI, CVA, CAD
- ☐ Mental health, Depression, Substance Abuse
- ☐ Cancer
- ☐ Dementia - Alzheimer's
- ☐ Post Surgical Procedure
- ☐ End Stage Renal Disease (ESRD), Dialysis
- ☐ Other_____

Other Risk Factors (Check all that apply)
- ☐ LOS > 7 days for most recent admission
- ☐ Limited caregiver support / Lives alone
- ☐ 2+ hospitalizations or ED visits in past 4 months
- ☐ 5 to 9 medications
- ☐ Radiation / chemotherapy / immunotherapy
- ☐ Cognitive impairment (Dependent Question below)

Level of Impairment: ☐Mild, ☐Moderate, ☐Severe

- ☐ > 2 psychosocial needs ☐ Home safety
- ☐ Extensive DME needs

Greatest Need (Brief Synopsis of Request)