External
Care Management Referral Form

ACC/DDD/RBHA [h . : email form to AcuteCMReferral@mercycareaz.org

DCS CHP LOB: email form to MCPDCSCHPCMReferral@AETNA.com

MCA LOB: email form to MCACMReferral@mercycareaz.org

INDIVIDUAL SENDING THE REFERRAL					
Referred by:		Referral Source:	*Select from drop down	Date:	

MEMBER INFORMATION			
Member Name:		Member DOB:	
Member A#:		Current Tel. #	
CHP ID#:		Current CHP ID Tel. #	
Current address:			
Facility Name/Type:			
Primary Line of Business:	Select LOB	Language:	

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.
☐ Financial Concerns/Benefits Needed: (Explain)	
☐ Discharge Barriers: (Explain)	
☐ Disease or Chronic Condition Unmanaged: (Explain)	Choose an item.
☐ Domestic Violence/Abuse: (Explain) Adult ☐ Protective Services (APS) report filed?	
☐ Alcohol (ETOH) / Drug Abuse / Medication-Assisted Treatment (MAT)/Opiate Use Disorder (OUD): (Explain)	
☐ Durable Medical Equipment - DME Needed:	
☐ Arizona Long Term Care (ALTCS) / Assertive Community Treatment (ACT) Referral needed:	
☐ Frequent Emergency Room (ER) Visits: (How many over (x) months)	
☐ Hearing/Vision (Deaf/Blind):	
☐ High Risk Pregnancy (Refer all DCS members) ☐ Neonatal Intensive Care Unit (NICU) >30 days: NAS: ☐	
☐ Complex Social Determinants of Health Needs:	Transportation Needs
☐ Left Against Medical Advice + Readmission <30 days:	
☐ Medication Non-adherence:	
☐ Department of Child Safety Comprehensive Health Plan (DCS/CHP): Triage for stratification to appropriate LOC:	
☐ Other: (Explain)	
☐ Veteran: (Yes/No)	

Comments and/or clinical information to support information above: