COORDINATION OF CARE
SCREENING AND REFERRAL FORM

Patient Name:	**Date of birth**:
ID #:	**Date of referral:**
Best phone # to reach member:	
Special contact information: (best time to call, HIPAA release on file, etc.):	
Plan name: Global Health	**LOB**: **Commercial** or **Medicare/Generations**

Review member record and assess for following diagnostic triggers:

Medical diagnoses: Choose one	**Behavioral health diagnoses:** Choose one
☐ **Substance abuse screening questions** Have you misused any Rx medication, used street drugs, or abused alcohol in the past 3 months? ☐ During the past 3 months, has your use of drugs or alcohol led to any health, social, employment, legal or family problems? ☐ unsuccessfully tried to cut down or quit? ☐ Have NOT able to screen member, but have CLEAR data that substance abuse/medical needs are untreated and require timely intervention to prevent deterioration. (Enter as much info as available into Comments section below)	**Depression screening questions** ☐ Over the past two weeks, have you felt little interest or pleasure in doing things? ☐ Over the past two weeks, have you felt down, depressed or helpless? ☐ NOT able to screen member, but have CLEAR data that mental health/medical needs are untreated and require timely intervention to prevent deterioration. (Enter as much info as available into Comments section below)

Screening questions		
Are you currently receiving treatment for any of the (medical or BH) conditions indicated above?	**Yes** ☐	**No** ☐
Are you satisfied with the care you are receiving?	**Yes** ☐	**No** ☐
Do you have any questions or concerns about your current treatment?	**No** ☐	**Yes** ☐
Would you be interested in receiving additional services or case management?	**No** ☐	**Yes** ☐
Comments:	Would you like educational materials regarding Depression or Substance abuse (if triggered)	Would you like a case manager to contact you regarding additional services?
	Yes ☒ *Complete page 2 and forward for follow-up and tracking*	

____Standard ------ **Urgent** (requires outreach within one business day due to acuity of symptoms)

Special contact information: (best time to call, HIPAA release on file, etc.)

Outcome Response (to be completed by receiving Case Manager)

Date of contact:

Check all that apply and describe briefly below:

- ☐ **Assessment/education [including sent clinical brochure(s)]**
- ☐ **Referral to support group/community resource**
- ☐ **Referral to provider**
- ☐ **Scheduled routine appointment**
- ☐ **Scheduled urgent/emergent appointment**
- ☐ **Referred member to emergency room**
- ☐ **Enrolled in ICM/ disease management**
- ☐ **Unable to contact member; letter sent. Date mailed:**
- ☐ **Member already in treatment, declined further assistance**
- ☐ **Member declined assistance / referrals**
- ☐ **Member admitted to MH/SA treatment (IP, PHP, IOP)**
- ☐ **Other:**

Additional notes: