Care at Home

Clinical referral form for Medicare HMO/PPO member

(Excludes those already enrolled in hospice, transplant candidates, and those under age 18)
For urgent referrals requiring a home visit in less than 72 hours, please call 1-877-239-1491

REFERRAL SOURCE

Name: _____

Today's date: _____ Phone: _____

Fax: _____ Email: _____

PATIENT INFORMATION

First name: _____ Last name: _____ M.I.: _____

Member ID: _____ D.O.B.: _____ Gender: _____

Street address: _____ City, State, Zip: _____ Apt.: _____

Phone: _____

PROVIDER DETAILS

PCP name: _____ Phone: _____ Fax: _____

Street address: _____ City, State, Zip: _____ Suite: _____

REFERRAL REASON

All relevant diagnoses: _____

Clinical and utilization

- ☐ Potentially avoidable facility-based (acute or SNF) admission over the last six months
- ☐ Two or more acute admissions in 12-month period related to chronic diagnoses
- ☐ History of re-admission to acute setting in less than 45 days
- ☐ High risk for exacerbation of an underlying chronic condition
- ☐ Disease combinations such as CHF/diabetes; CHF/CAD
- ☐ Recently discharged from hospital

Date of discharge: _____

Name of facility: _____

Behavioral, psychosocial, and/or functional risks

- ☐ Adherence issues where traditional interventions have proven unsuccessful
- ☐ Temporary or permanent bed-bound status that requires ongoing management of persistent co-morbidities or complications
- ☐ Declining functional or cognitive capacity or impairment of ADLs
- ☐ Ongoing chronic pain issues and associated complications of pain management
- ☐ Underlying mental health issues or altered coping skills
- ☐ Greater than eight medications with high risk or history of side effects or adverse effects

Additional notes: _____

If available, please include all relevant medical records with referral (e.g., current medications, most recent lab results, chronic problems list, last history and physical or visit notes).

Fax completed form to 1-844-574-2616

BlueShield of Northeastern New York

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