

NICU / PEDIATRIC CASE MANAGEMENT REFERRAL FORM

STEWARD HEALTH CHOICE UTAH



HEALTH CHOICE
UTAH

To refer a member for case management services,
please complete and return this form via a secure email or fax to:

Integrated Care Coordination / Case Management

Email: HCH.CaseManagementReferral@steward.org • Fax: 801-758-3370

Referral Priority: **Urgent** (0-7 Days) **Routine** (10-14 Days)

MEMBER INFORMATION

Health Choice Member ID:	Member name:	Date of Birth:
Current / Best Phone Number to Reach Member:	Best Time to Call Member:	
Referral Source (Internal, PCP Office, Hospital, Matrix):		
Person Referring:	Person Referring Contact Information:	

Case Management's goal is to promote the member's wellness, autonomy and appropriate use of service and financial resources.

REASON FOR REFERRAL / CRITERIA (Please check all that apply):

Emergency Room Visits or Hospitalizations of two (2) or more admissions in less than six months.

Chronic Condition (e.g. Asthma, CHF, COPD, CAD, Diabetes, HTN)

Diagnosis: _____

Specialty Condition (e.g. MS, Parkinson's Disease, ALS, Lupus, Rheumatoid Arthritis, Cystic Fibrosis, Hemophilia, Sickle Cell Disease)

Diagnosis: _____

Behavioral / Mental Health Needs (please describe):

Non-Compliance with Treatment / Medications

Education on diagnosis, medications and self-management.

High Risk OB (please describe):

Resources for Social Needs / Financial Assistance (please describe):

Other (please describe):

NICU - In-Patient

- Cardiac Defects
- RDS
- Failure to thrive
- < 34 Weeks
- Apnea
- Congenital Defects
- Other:

NICU -Graduate

- Cardiac Defects
- RDS
- Failure to thrive
- < 34 Weeks
- Apnea
- Congenital Defects
- Other:
