MEDICALLY FRAGILE CASE MANAGEMENT PROGRAM

UNM CDD 2300 Menaul Blvd NE • Albuquerque NM 87107 • 505-272-2910 • Fax: 505-272-8100

REFERRAL

PLEASE CONSULT WITH FAMILY PRIOR TO REFERRAL SO THEY ARE AWARE A REFERRAL IS BEING MADE

NOTE: THIS FORM CONTAINS PHI. HIPAA REQUIRES THAT IT BE ENCRYPTED PRIOR TO EMAILING

Complete the entire form, encrypt and email to CDD-MedFrag@salud.unm.edu or you can fax or mail back to address above.

CLIENT INFORMATION

Date of Referral: **MFCMP OFFICE USE ONLY: ID #:** **Initial Contact Attempt:** **Status:**

Last name: **First name:**

D.O.B.	**Gender:** M ☐ F ☐	**SSN:**	**SSI:** ☐ No ☐ Yes ☐ Applied
MRN:	**Medicaid :** ☐ No ☐ Yes ☐ Applied	**Medicare:** ☐ No ☐ Yes ☐ Applied	
MCO Name:	**MCO Number:**	**Private Ins:** ☐ No ☐ Yes Name:	

PRIMARY Diagnosis: (**CHOOSE ONE**)	**ICD 10 Code:**	**Primary Physician/phone number:**

Other Diagnosis/ICD 10 Codes:

Parent/s:

Address/Mailing (includes street, city and zip code):

Address/Physical(includes street, city and zip code):

Telephone number : (H)	(C) (C)	**E-mail:**
Guardian:	**Relationship:**	**Foster Placement:** ☐ No ☐ Yes Agency:

Address:

Telephone number: (H)	(C) (C)	**E-mail:**

Primary Language: ☐ English ☐ Spanish ☐ American Sign Language ☐ Other: describe

Preferred Ethnicity: ☐ Afro-American ☐ Anglo-American/Caucasian ☐ Asian American ☐ Hispanic/Latino ☐ Mexican American ☐ Native American/preferred tribal selection: ☐ Other: ☐ Prefer not to answer

Currently Inpatient? ☐ No ☐ Yes **Date of latest hospitalization** ☐ **admit date** ☐ **d/c date:**

Hospital: **Reason for admission:**

PLEASE COMPLETE SECTION BELOW ON ALL REFERRALS

REFERRAL SOURCE

Referrer's Name:		**Facility**:
Phone #: **Pager:**	**Fax:**	**E-mail:**

Skilled Care Needed (in-home nursing) - What needs require a skilled nurse in the home? (Click box to mark with X)

PULMONARY: ☐Trach ☐Vent24/7 ☐VentHS ☐CPT Vest ☐O2-24/7 ☐O2 HS ☐O2 PRN ☐CPAP ☐BiPAP ☐Pulse ox Suctioning: ☐bulb syringe ☐Yankauer ☐ Deep suctioning ☐Other:

NEURO/MUSC: ☐Sz intractable ☐Sz Gran Mal ☐Sz>3x/d ☐Spasticity/ROM ☐Hypotonicity

GI: ☐Oral feed only ☐Tube feed only ☐Combination oral/tube feed ☐TPN ☐Aspiration issues

Meds: ☐Oral ☐Tube ☐Injxn ☐IV ☐Nasal ☐Ophthal ☐Topical ☐PR ☐# Nebs/day ☐# Meds/day:

ADL Level Assistance Required (for children > 3 years of age): Bathing (☐ Partial ☐Total)

Incontinence ☐Urine ☐ Bowel ☐Ostomy bag Feeding (☐ Partial ☐Total) Dressing (☐ Partial ☐Total)

Positioning needs: ☐with feeds ☐while seated ☐bed ☐special wedges or pillows ☐special seating

DME: ☐W/C ☐Walker ☐AFOs ☐HKAFOs ☐Gait trainer ☐Hand splints ☐Knee splints ☐Other

OTHER MEDICAL: ☐IVH Gr ☐VNS ☐Cardiac ☐GER ☐Foley Cath ☐In & Out Catheterizations

COMMENTS: (Contact Medically Fragile centralized referral email CDD-MedFrag@salud.unm.edu with any questions.)

Services Currently Being Received: ☐EI Agency Name ☐OT ☐PT ☐SLP ☐DS ☐Vision ☐Feeding ☐Developmental Care ☐PCS ☐MCO Care Coord (name & contact # if known):

Services to be referred: ☐PCS ☐EI ☐OT ☐PT ☐SLP ☐DS ☐Vision ☐Feeding ☐Developmental Care ☐Other

Any Waiver Applications Completed and Faxed?: ☐DDW date: ☐Centennial Waiver date: ☐MFW date: