

VITAL CARE
Case Management Referral Form

Patient Name: _____

DOB: _____

Family/Caregiver (Name and Phone): _____

Completed by: _____

PCP: _____

Date: _____

Case Management Referral Criteria: Patients with ≥ 2 chronic medical conditions plus 1 High Risk Criteria; or 1 poorly controlled chronic medical condition plus 2 High Risk Criteria; or direct approval by Case Management Medical Director.



Chronic Medical Conditions

- | | | |
|-------------------------------------|----------------------------------|--|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> HTN | <input type="checkbox"/> Wound Problem |
| <input type="checkbox"/> Depression | <input type="checkbox"/> PVD | <input type="checkbox"/> Cancer: |
| <input type="checkbox"/> Dementia | <input type="checkbox"/> CAD | <input type="checkbox"/> CVA hx |
| <input type="checkbox"/> CHF | <input type="checkbox"/> ESRD | <input type="checkbox"/> AIDS/HIV |
| <input type="checkbox"/> COPD | <input type="checkbox"/> Obesity | <input type="checkbox"/> Anticoagulation |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> CKD | <input type="checkbox"/> Others: _____ |

Past Surgical History

- : _____
 : _____
 : _____

High Risk Criteria

- | | |
|---|---|
| <input type="checkbox"/> Poor Social Support: | <input type="checkbox"/> Psychological Condition: |
| <input type="checkbox"/> Poor Functional Status: | <input type="checkbox"/> Substance Abuse, Tob, Etoh, non-compliance: |
| <input type="checkbox"/> Poor Nutritional Status: | <input type="checkbox"/> ≥ 2 Hospitalizations or ≥ 3 ER visits in previous year |

Medications - Medications Not Available

1)	2)	3)
4)	5)	6)
7)	8)	9)
10)	11)	12)
13)	14)	15)

Additional Comments: _____

