

## Clinical Programs Referral Form

**To make referral, fax completed form to 952-853-8745 or call the intake line at 952-883-5469 or 1-800-871-9243**

All member referrals will be evaluated; Enrollment criteria must be met to qualify for program admission.

(Shaded fields are required)

### Referral Source

From (Name and Title):	Department/Clinic:	Referral Date:
Phone:	Fax:	E-mail Address:

### Member Information

Member Name:	Member Phone:
Member DOB:	Best Time to Call:
Member ID:	Member Address:
Language Preference:	Gender:    Male            Female
Provider Name:	Is Member Aware of Referral? Yes            No
Reason for Referral:	Provider Phone:
Hospital Discharge Date:	

### Disease/Condition Programs

<p style="text-align: center;"><b><u>Case Management Programs</u></b> <b><u>For patients and members at risk of hospitalization</u></b></p> <p><input type="checkbox"/> <b><u>Medical</u></b> - Case Management Specify situation/condition: _____</p> <p><input type="checkbox"/> <b><u>Behavioral Health</u></b> - Case Management  <input type="checkbox"/> Schizophrenia      <input type="checkbox"/> Major Depression (2 Hosp. in 1 year)  <input type="checkbox"/> Bipolar Disorder      <input type="checkbox"/> Dual Dx-Chem Health/Mental Health  <input type="checkbox"/> Children/adolescents at risk for out of home placement/psychiatric residential tx.</p> <p><input type="checkbox"/> <b><u>Restricted Recipient Program</u></b> - Chemical misuse/addiction; inappropriately seeking care from multiple providers</p>	<p style="text-align: center;"><b><u>Wellness Programs</u></b></p> <p><input type="checkbox"/> Tobacco Cessation  <input type="checkbox"/> Adult Obesity Telephone Coaching – (for HealthPartners commercial medical members over the age of 18 and with a BMI &gt; 30 only)</p> <p style="text-align: center;">-----</p> <p style="text-align: center;"><b><u>Pharmacy Programs</u></b></p> <p><input type="checkbox"/> MTM (Medication Therapy Mgmt including Herbal Pharmacy)</p> <hr/> <p>Other: _____</p> <p>Comments: _____</p>																												
<p style="text-align: center;"><b><u>Disease/ Condition Programs</u></b></p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; border: none;"><input type="checkbox"/> Asthma</td> <td style="width: 50%; border: none;"><input type="checkbox"/> ALS</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Coronary Artery Disease</td> <td style="border: none;"><input type="checkbox"/> CIDP</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> COPD</td> <td style="border: none;"><input type="checkbox"/> Cystic Fibrosis</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Diabetes</td> <td style="border: none;"><input type="checkbox"/> Dermatomyositis</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Heart Failure</td> <td style="border: none;"><input type="checkbox"/> Gaucher Disease</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Healthy Pregnancy</td> <td style="border: none;"><input type="checkbox"/> Hemophilia</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Cancer</td> <td style="border: none;"><input type="checkbox"/> Multiple Sclerosis</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Back Pain</td> <td style="border: none;"><input type="checkbox"/> Myasthenia Gravis</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Parkinson's Disease</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Polymyositis</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Rheumatoid Arthritis</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Scleroderma</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Sickle Cell Anemia</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Systemic Lupus</td> </tr> </table>		<input type="checkbox"/> Asthma	<input type="checkbox"/> ALS	<input type="checkbox"/> Coronary Artery Disease	<input type="checkbox"/> CIDP	<input type="checkbox"/> COPD	<input type="checkbox"/> Cystic Fibrosis	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Dermatomyositis	<input type="checkbox"/> Heart Failure	<input type="checkbox"/> Gaucher Disease	<input type="checkbox"/> Healthy Pregnancy	<input type="checkbox"/> Hemophilia	<input type="checkbox"/> Cancer	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Back Pain	<input type="checkbox"/> Myasthenia Gravis		<input type="checkbox"/> Parkinson's Disease		<input type="checkbox"/> Polymyositis		<input type="checkbox"/> Rheumatoid Arthritis		<input type="checkbox"/> Scleroderma		<input type="checkbox"/> Sickle Cell Anemia		<input type="checkbox"/> Systemic Lupus
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