

Fax: 1-888-670-7260 or Email: pcnprecert@cmpcn.org

Care Integration Phone: (888) 670-7262

☐ Pediatric Care Network (PCN-Medicaid) ☐ Children's Mercy Health Network (CMHN-Commercial: Blue KC)

Today's Date: _____ Member Name: _____

Member ID: _____

Gender: _____ Member DOB: _____

Caregiver Name: _____ Phone Number: _____

Referral Source

Office/Clinic Name: _____

Phone: _____ Fax: _____

PCP Name: _____

Referral Reason / DX (check all that apply):	Asthma	Behavioral / Psychosocial	Case Management	Diabetes	OB
	<input type="checkbox"/> Missed Appointments <input type="checkbox"/> Needs Asthma Education Reinforcement <input type="checkbox"/> New Diagnosis <input type="checkbox"/> OB member with Asthma <input type="checkbox"/> Rx Non-adherence <input type="checkbox"/> OTHER (specify below)	<input type="checkbox"/> Assistance with IEP or School-based Services <input type="checkbox"/> Limited Support System <input type="checkbox"/> Community Resources <input type="checkbox"/> Behavioral Health Needs <input type="checkbox"/> Domestic Violence <input type="checkbox"/> Substance Abuse <input type="checkbox"/> Screening Attached <input type="checkbox"/> Depression <input type="checkbox"/> OTHER (specify below)	<input type="checkbox"/> Autism <input type="checkbox"/> Chronic Medical Condition (list: _____) <input type="checkbox"/> Complex Medical Needs <input type="checkbox"/> Frequent Use of ER Services <input type="checkbox"/> Lead Toxicity <input type="checkbox"/> Med/Behavioral Health Needs <input type="checkbox"/> New Diagnosis (specify below) _____ <input type="checkbox"/> Non-adherence with Treatment Plan <input type="checkbox"/> Premature Birth with Complications <input type="checkbox"/> Rx Non-adherence <input type="checkbox"/> Special Health Care Needs <input type="checkbox"/> Transplant <input type="checkbox"/> Weight Management <input type="checkbox"/> OTHER (specify below)	<input type="checkbox"/> Pre-diabetes <input type="checkbox"/> Type I New Diagnosis <input type="checkbox"/> Type I New to Insulin <input type="checkbox"/> Type I Recent/multiple DKA Episodes <input type="checkbox"/> Type I Uncontrolled <input type="checkbox"/> Type II New Diagnosis <input type="checkbox"/> Type II New to Insulin <input type="checkbox"/> Type I or Type II Recurring Hypoglycemia <input type="checkbox"/> Type II Uncontrolled <input type="checkbox"/> OTHER (specify below)	<input type="checkbox"/> Chronic Medical Condition Affecting Pregnancy <input type="checkbox"/> History of PIH, HELLP, or Fatty Liver of Pregnancy <input type="checkbox"/> History of Preterm Labor <input type="checkbox"/> HIV <input type="checkbox"/> Hyperemesis Gravidarum <input type="checkbox"/> Incompetent Cervix <input type="checkbox"/> Multiple Birth Pregnancy <input type="checkbox"/> Placenta Previa <input type="checkbox"/> Substance Abuse <input type="checkbox"/> Under Age 18 <input type="checkbox"/> OTHER (specify below)

Referral Reason / Dx Notes:

Recent Clinical History
 including: Hospitalizations, Medications, ER Visits, BMI

Barriers to Treatment (check all that apply):

<input type="checkbox"/> Financial	<input type="checkbox"/> No Phone	<input type="checkbox"/> Food Insecurity	<input type="checkbox"/> Housing	<input type="checkbox"/> Physical Limitations
<input type="checkbox"/> Transportation	<input type="checkbox"/> Lack of Support	<input type="checkbox"/> Other		

For CMHN practices: If you do not want Children's Mercy Integrated Care Solutions to contact a patient on your risk report, please check this box ☐. Timeframe for exclusion: ☐ Permanently, ☐ 3 Months, ☐ 6 Months, ☐ 12 Months