Children's Mercy PEDIATRIC CARE NETWORK

Toll Free MO PCN Phone: 1-877-347-9367
Toll Free KS PCN Phone: 1-833-802-6427

Referral Form for Case Management and Disease Management

Fax to: **1-888-670-7260**

Member Name:		
Member ID:		
Gender:	Male ◯ Female ◯	**DOB:**
Referral Source	Name: _____ Office/clinic: _____ Phone: _____ Fax: _____ Today's date: _____	

Referral Reason/ Dx	**Asthma**	**Behavioral/ Psychosocial**	**Case Management**	**Diabetes**	**OB**
	☐ Missed appointments ☐ Needs asthma education Reinforcement ☐ New diagnosis ☐ OB member with asthma ☐ Rx non-adherence ☐ **OTHER (specify below)**	☐ Assistance with IEP or school-based services ☐ Limited support system ☐ Community Resources ☐ Behavioral Health needs ☐ Domestic Violence ☐ Substance Abuse ☐ Screening attached ☐ Depression ☐ **OTHER (specify below)**	☐ Autism ☐ Chronic medical condition (list: _____) ☐ Complex medical needs ☐ Frequent use of ER services ☐ Lead Toxicity ☐ Med/Behavioral Health needs ☐ New diagnosis **(specify below)** ☐ Non-compliance with treatment plan ☐ Premature birth with complications ☐ Rx non-adherence ☐ Special Health Care Needs ☐ Transplant ☐ **OTHER (specify below)**	☐ Pre-diabetes ☐ Type I new diagnosis ☐ Type I new to insulin ☐ Type I recent/multiple DKA episodes ☐ Type I uncontrolled ☐ Type II new diagnosis ☐ Type II new to insulin ☐ Type I or type II recurring hypoglycemia ☐ Type II uncontrolled ☐ **OTHER (specify below)**	☐ Chronic medical condition affecting pregnancy ☐ History of PIH, HELLP, or Fatty Liver of pregnancy ☐ History of preterm labor ☐ HIV ☐ Hyperemesis gravidarum ☐ Incompetent cervix ☐ Multiple birth pregnancy ☐ Placenta previa ☐ Substance abuse ☐ Under age 18 ☐ **OTHER (specify below)**

Referral Reason/ Dx Notes:	
PCP/ Specialists:	
Caregiver's Name/Phone Number:	
Recent Clinical History including: • Hospitalizations • Medications • ER visits • BMI	