MDX Hawai'i Care Coordination Referral Form

FAX TO (808) 792-8441 (O'ahu)/1-833-711-1663 (Neighbor Islands)
(808) 792-8402 (O'ahu)/1-877-544-0777 (Neighbor Islands)

This form is for Referral to MDX Hawai'i's Medical Management Department. *Please complete all fields on both pages* and **fax** this form to MDX Hawai'i. Please include any relevant medical records with this form.

SUBMITTED DATE	REFERRING PROVIDER NAME
PHONE	CONTACT PERSON

MEMBER INFORMATION

MEMBER NAME: (LAST, FIRST M.I.)		
MEMBER ID	DOB	PHONE

PROVIDER INFORMATION (if applicable)

PRIMARY CARE PHYSICIAN	PHONE	FAX
SPECIALTY PHYSICIAN	PHONE	FAX
BEHAVIORAL HEALTH PHYSICIAN	PHONE	FAX

REASON FOR REFERRAL TO CARE COORDINATION (check "✓" all that apply)

SERVICE COORDINATION

- ☐ **Health Plan Benefits** assist member to understand and access benefits
- ☐ **Mom's Meals Benefit** meals provided after discharge from SNF or hospital (if member meets benefit criteria)
- ☐ **Medication Copays** provide possible resources to assist with cost of medications
- ☐ **Transportation** provide possible resources for transportation to medical appointments
- ☐ **Food Insecurity** provide possible resources if member facing food insecurity
- ☐ **Community Resources** assist member to understand & access available resources

CARE COORDINATION & COMPLEX CASE MANAGEMENT

- ☐ **CKD Self-Management**
  - condition education
  - medication education
  - Advanced Care Planning
- ☐ **ESRD**
  - condition education
  - optimal starts
  - fluid overload
- ☐ **Heart Disease Self-Management**
  - condition education
  - medication education
  - Advanced Care Planning
- ☐ **Diabetes Self-Management**
  - condition education
  - medication education
  - Advanced Care Planning
- ☐ **Two or More Inpatient Admissions** within last year
  - Chronic Kidney Disease
  - Heart Disease
- ☐ **Two or More ER Visits** within last 6 months
  - Chronic Kidney Disease
  - Heart Disease

ALA 'O HO'OLA (*High risk patients who require home or telehealth visits by APRN)

- ☐ **Complex Chronic Condition Assessment** for High-Risk Patients
  - recommendations for complex plan of care
- ☐ **Two or More Inpatient Admissions** within last year or **Two or More ER Visits** within last 6 months
- ☐ **Medication Reconciliation** and/or coordination
  - Education provided on medications
- ☐ **Advance Care Planning** Education provided on
  - Advanced Directives
  - POLST
- ☐ **Education & Training**
  - pathophysiology and management of chronic diseases
    >blood pressure
    >glucometer and blood sugar measurement
    >monitoring daily weight
    >diet education

☐ **Behavioral Health** – Assistance with finding a Behavioral Health Provider or Services

COVID 19 Vaccination Status

- ☐ Vaccinated and boosted
- ☐ Vaccinated, but not boosted
- ☐ Not vaccinated

Important information for the case manager (eg. best time to call, special needs such as hearing impairment, speaks language other than English-please identify language, etc.) _____

Please explain any resources or interventions that have already been provided _____

- ☐ No resources nor interventions have been provided

Please explain your goals for this intervention and specific desired outcomes _____

Please confirm the following

- ☐ My patient is aware that I referred him/her to case management
- ☐ I have attached recent clinical notes, pertinent labs and tests, and the current medication list
- ☐ If my patient is unable to engage with the case management team, I have attached a POA