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OXNARD FAMILY CIRCLE
ADULT DAY HEALTH CARE CENTER

Enhance Care Management Referral

Ph. 805-385-4180 * Fax. 805-751-4149 * email ECM@oxnardfamilycircle.com

- Date of Request: _____

Member Information:

- Member's Name:
  First Name _____Last Name_____
- Member's Date of Birth: _____
- Member's Medi-Cal Client ID Number:_____GCHP: ☐ Yes ☐ No; Kaiser: ☐ Yes ☐ No
- Member's Address (if available):_____
- Member's Primary Phone Number:_____
- Member's Email (if available):_____
- Language: ☐ English speaking ☐ English not primary language
- Member's Preferred Language: _____
- Social Determinants of Health (SDOH) ICD-10 Diagnosis Identified within prior 12 months [Check all that apply]:
  - ☐ Z55.0 Illiteracy and low-level literacy
  - ☐ Z59.0 Homelessness
  - ☐ Z59.10 Inadequate housing (unspecified)
  - ☐ Z59.3 Problems related to living in residential institution
  - ☐ Z59.4 Lack of adequate food and safe drinking water
  - ☐ Z59.7 Insufficient social insurance and welfare support
  - ☐ Z59.8 Other problems related to housing and economic circumstances
  - ☐ Z59.811 Housing instability, with risk of homelessness
  - ☐ Z60.2 Problems related to living alone
  - ☐ Z59.812 Housing instability, with homelessness in last 12 months
  - ☐ Z60.4 Social exclusion and rejection (physical appearance, illness, or behavior)
  - ☐ Z62.819 Personal history of unspecified abuse in childhood
  - ☐ Z63.0 Problems in relationship with spouse or partner
  - ☐ Z63.5 Disruption of family by separation and divorce (marital estrangement)
  - ☐ Z63.6 Dependent relative needing care at home
  - ☐ Z63.72 Alcoholism and drug addiction in family
  - ☐ Z65.1 Imprisonment and other incarceration
  - ☐ Z65.2 Problems related to release from prison
  - ☐ Z65.8 Other specified problems related to psychosocial circumstances (religious or spiritual problem)

Referral Source Information:

- Referral By: ☐ Hospital ☐ SNF ☐ Outpatient Clinic ☐ Community Outreach
- Referring Organization Name: _____
- Referring Individual Name: _____
- Referrer Phone Number: _____
- Referrer Fax Number: _____
- Referring Individual Email: _____
- Referring Attending/Provider: _____

Referral Information:

- Expected Discharge Date: _____
- Diagnoses/Reason(s) for Admission: _____
- Any Known Allergies: _____
- Any Dietary Restrictions: _____

Mental/Physical Health Information:

- History of Mental Health (MH) Issues: ☐ Yes ☐ No
- Clinical Chronic Conditions: ☐ Asthma ☐ CHF ☐ Chronic Kidney Disease ☐ Chronic Liver Disease ☐ COPD ☐ Diabetes ☐ Coronary artery disease ☐ Hypertension ☐ HIV/Aids ☐ Cancer
- Attached is a List of Other Known Medical Conditions: ☐ Yes ☐ No
- TB Test or Chest X-Ray Performed: ☐ Yes ☐ No
- Any Communicable Disease (If YES, please attach documentation): ☐ Yes ☐ No
- Colonized (If YES, please attach documentation): ☐ Yes ☐ No
- Covid-19 Test Performed (If YES, please include documentation): ☐ Yes ☐ No

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Wound Care:

- Does Member Require Wound Care?
  ☐ Yes ☐ No

Substance Use:

- Alcohol: ☐ Yes ☐ No
- Smoking: ☐ Yes ☐ No
- Cocaine: ☐ Yes ☐ No
- Opioids or Painkillers: ☐ Yes ☐ No
- Heroine: ☐ Yes ☐ No
- Methamphetamine: ☐ Yes ☐ No
- Methadone Clinic needed? ☐ Yes ☐ No ☐ Other

Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL):

- Is Member Independent with ADLs? ☐ Yes ☐ No
- Is Member Independent with IADLs? ☐ Yes ☐ No

Medical Stability and Care:

- Self-Administering medication:
  ☐ Yes, 100% independently ☐ No, needs reminders ☐ No, needs reminders and assistance
- Is Member continent with bladder? ☐ Yes ☐ No
- Is Member continent with bowel? ☐ Yes ☐ No
- Does Member require colostomy care? ☐ Yes ☐ No
- Does Member require catheter care? ☐ Yes ☐ No
- Does Member require antibiotics? ☐ Yes ☐ No
  Does Member require an IV infusion? ☐ Yes ☐ No
- (If YES, please provide documentation):
- Alcohol detox needed? ☐ Yes ☐ No

Durable Medical Equipment (DME) Dependent:

- Does Member require a Walker? ☐ Yes ☐ No
- Does Member require a Cane? ☐ Yes ☐ No
- Does Member require Crutches? ☐ Yes ☐ No
- Does Member require a Wheelchair? ☐ Yes ☐ No
- Does Member require Oxygen? ☐ Yes ☐ No
- Does Member require Wound Vac? ☐ Yes ☐ No
- Does Member require a BiPAP? ☐ Yes ☐ No
- Does Member require a CPAP? ☐ Yes ☐ No
- Does Member require any other DME? [Please list]: _____

Additional Clinical Information:

- Does Member require Medication? (If YES, please attach Rx list): ☐ Yes ☐ No
- Attached is the List of All Known Medications Taking if Available: ☐ Yes ☐ No
- Does Member require Medication Management and Education? ☐ Yes ☐ No
- Does Member require Physical Therapy? ☐ Yes ☐ No

Please Attach Following Information if Available:

- Included in Submission: ☐ Consent Form ☐ Release of Information
  ☐ Face Sheet ☐ CXR or PPD (TB) ☐ History & Physical ☐ S.W. Notes ☐ Consultation Notes
  ☐ Recent PT/OT/Speech ☐ Medication List ☐ Wound Care Notes ☐ Psych Notes (please include last 2 days of nursing documentation) ☐ Covid-19 Test result (within last 24 hours)
  ☐ Home Health Provider Info ☐ All RXs list
- Comments or Other Files Attached:
  _____
  _____