

REFERRAL

FOR CASE MANAGEMENT FOR CHILDREN AND PREGNANT WOMEN

REFERRAL			
Referral Date:	Name of Referral Source (List agency/company name):	Name of Person Making Referral:	
Referral Source (Please check one): <div style="display: flex; flex-wrap: wrap;"> <div style="width: 25%;"><input type="checkbox"/> Health Care Provider</div> <div style="width: 25%;"><input type="checkbox"/> Community Agency</div> <div style="width: 25%;"><input type="checkbox"/> School</div> <div style="width: 25%;"><input type="checkbox"/> ECI</div> <div style="width: 25%;"><input type="checkbox"/> City or County Health Department</div> <div style="width: 25%;"><input type="checkbox"/> Health Plan</div> <div style="width: 25%;"><input type="checkbox"/> Individual</div> <div style="width: 25%;"><input type="checkbox"/> State Agency:</div> <div style="width: 25%;"><input type="checkbox"/> Other</div> </div>			
Phone Number for Person Making Referral:	Fax Number for Person Making Referral:		
Do you Desire Information Regarding the Status of the Referral? <input type="checkbox"/> YES <input type="checkbox"/> NO			

CLIENT INFORMATION				
Client Name:		DOB:	<input type="checkbox"/> Male <input type="checkbox"/> Female	
Medicaid #:	Describe Medical/Health Condition/Risk or High-Risk Pregnancy Condition:			
Parent/Guardian Name (if client is under 18):		Language Preference:		
Residential Address:		City:	ZIP:	County:
Phone Numbers-	Home:	Work:	Cell:	Other:

ADDITIONAL INFORMATION
Reason for Referral/Need for case management:
Priority Status of Referral: <input type="checkbox"/> Urgent (needs to be contacted within 2 working days) <input type="checkbox"/> Standard (needs to be contacted within 7 working days)

FOR MORE INFORMATION ABOUT CASE MANAGEMENT, GO TO:

<http://hhs.texas.gov/case-management-provider>

FAX TO: THSTEPS SPECIAL SERVICES UNIT FAX # (512) 533-3867

FOR SSU USE ONLY	
Referral Assigned To SSU CCR: _____ Date: _____	
Date of Attempts:	Action:
1.	
2.	
3.	
Date Completed: <input type="checkbox"/> Scheduled Appointment with: <input type="checkbox"/> Successful Phone Contact/Gave provider information by phone and mailed List <input type="checkbox"/> Successful Phone Contact/Mailed Provider List <input type="checkbox"/> Successful Phone Contact/Not interested in case management <input type="checkbox"/> Successful Phone Contact/No case management needs <input type="checkbox"/> Unable to contact/Mailed provider list	
Attempts Made to contact Provider:	
Date of Attempts:	Action:
1.	
2.	
3.	

FAX TO: THSTEPS SPECIAL SERVICES UNIT FAX # (512) 533-3867