

REQUEST FOR CASE MANAGEMENT INFORMING

FOR CASE MANAGEMENT FOR CHILDREN AND PREGNANT WOMEN

REFERRAL	
Referral Date:	Referral Source (Please check one): <input type="checkbox"/> Health Care Provider <input type="checkbox"/> Community Agency <input type="checkbox"/> School <input type="checkbox"/> Health Plan <input type="checkbox"/> Individual <input type="checkbox"/> Other
	Name of Referral Source (List agency/company name): Name of Person Making Referral:
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: ()

ONLY COMPLETE IF REFERRING OTHER FAMILY MEMBERS			
	Client #2	Client #3	Client #4
Client Name			
Medicaid #			
DOB			
Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female
Medical/Health Condition/Risk or High-Risk Pregnancy			

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

ADDITIONAL INFORMATION

Reason for Referral/Need for case management:

Priority Status of Referral: Urgent (needs to be contacted within 2 working days)
 Standard (needs to be contacted within 7 working days)

FOR SSU USE ONLY

Referral Assigned To SSU CCR: _____ Date: ___/___/___

Date of Attempts:	Action:
1.	
2.	
3.	

Date Completed: ___/___/___

- Scheduled Appointment with: _____
- Successful Phone Contact/Gave provider information by phone and mailed List
- Successful Phone Contact/Mailed Provider List
- Successful Phone Contact/Not interested in case management
- Successful Phone Contact/No case management needs
- Unable to contact/Mailed provider list

Attempts Made to contact Provider:

Date of Attempts:	Action:
1.	
2.	
3.	

FOR MORE INFORMATION ABOUT CASE MANAGEMENT, GO TO: <http://www.dshs.state.tx.us/caseman>

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