



## Disease Management Referral Form

Patient Information			
Patient Name	Date of Birth	UCare ID #	Product
Language Spoken: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Hmong <input type="checkbox"/> Somali <input type="checkbox"/> Russian <input type="checkbox"/> Other _____ Interpreter Needed: <input type="checkbox"/> Yes <input type="checkbox"/> No		Phone number	

Provider Information			
Primary Care Provider	Primary Care Clinic	Phone number	

Choose Program (For specifics – please refer to the DM Program Grid)	
<p><b>Health Coaching Eligibility:</b></p> <p><b>Diabetes- Health Journey</b></p> <ul style="list-style-type: none"> <li>5 [ Yg 18-75 yYUrs c`X</li> <li>GA [ ] ^A^c • AÖEQ • ] aqä aai } • A A@ Aee dG A [ ] c@</li> <li>Any UCare product</li> <li>Patients who would benefit from health coaching support</li> </ul> <p><b>Heart Failure – Healthy Hearts Program</b></p> <ul style="list-style-type: none"> <li>5 ges 18-8, yYUrs c`X`</li> <li>Must have a diagnosis of heart failure</li> <li>Any UCare product (A y&amp;Y) cMSHO Ag äÄ ÜÖÉ</li> <li>Less than 2 heart failure ED/hospitalizations in the last 15 months</li> </ul> <p style="color: red; margin-left: 20px;">**Refer to Medtronic's HF Telemonitoring Program if:</p> <ul style="list-style-type: none"> <li>Member is 89+ years old</li> <li>MSHO/MSc+ member</li> <li>2 or more heart failure ED/hospitalizations in the last 15 months</li> </ul> <p><b>Migraine Management Program</b></p> <ul style="list-style-type: none"> <li>Ages 18-75 years old</li> <li>1 or more migraine related encounters in the last 12 months</li> <li>1 or more pharmacy fill for migraine prescription in the last 12 months</li> <li>Connect, Connect+Medicare, MNCare, MSC+, and PMAP</li> <li>Patients who would benefit from health coaching support</li> </ul>	<p style="text-align: center;"><b>&lt;YUH '7 cUW ]b[ Programg:</b></p> <p><input type="checkbox"/> Diabetes</p> <p><input type="checkbox"/> Heart Failure</p> <p style="text-align: center;">Migraine</p> <p><b>Program Services:</b> Telephonic health coaching based on readiness to change, Self-management tools, if indicated.</p> <p><b>Is the member agreeable to participating in the indicated disease management program?</b>  <input type="checkbox"/> Yes</p> <p><b>Comments/Special Instructions</b></p> <p style="color: red; margin-top: 10px;"><b>**Exclusions to Disease Management Programs</b></p> <ul style="list-style-type: none"> <li>Diagnosis of ESRD (End Stage Renal Disease)</li> <li>On Hospice care</li> <li>In Long Term Care Facility</li> <li>On Dialysis</li> </ul>

Referral Source		
Referred by (name):	Phone	Do you want to be contacted regarding the status of this referral: <input type="checkbox"/> Yes <input type="checkbox"/> No

Please fax to UCare at: 612.884.2497