Mount Sinai Health Home

Referral of Patient to Mount Sinai Health Home

Date: ____________ **Referring Agency:** ______________________________

Name Person Making Referral: ______________________________

Phone Number: ______________________ **EMAIL:** ______________________________

Patient Demographics	
Patient Name: ______________________	**Patient Date of Birth:** ______________________
Patient Medicaid ID: ______________________	**Patient Address :** ______________________
Medicaid MCO: ☐ Yes ☐ No	______________________
MCO Name: ______________________	**Patient Phone Number:** ______________________

Medical Conditions (Check all that apply):	
☐ Diabetes	☐ Asthma
☐ Congestive Heart Failure	☐ Addiction
☐ Hypertension	☐ HIV/AIDS
☐ Mental Illness	☐ Other ______________________
☐ BMI over 25	☐ Other ______________________

Additional Assessment Items			
Does the patient have a PCP?	☐ Yes ☐ No	Is the patient homeless?	☐ Yes ☐ No
Does the patient have adequate social/family support?	☐ Yes ☐ No	Was the patient recently released from incarceration?	☐ Yes ☐ No
Does the patient have learning or cognitive issues?	☐ Yes ☐ No	Does the patient have deficits in daily living, i.e. dressing, hygiene?	☐ Yes ☐ No
Does the patient have a history of non-adherence to medication?	☐ Yes ☐ No	History of non-compliance with medical follow-up?	☐ Yes ☐ No
Has the patient had more than 2 visits to the ED in the last year	☐ Yes ☐ No If Yes, how many?____	Has the patient had more than 2 hospitalizations in the last year?	☐ Yes ☐ No If Yes, how many?____

How will the patient benefit from Care Coordination?

Referrals should be sent via secure, encrypted email to [illegible], [illegible] Coordinator – [illegible]@mountsinai.org or via fax at 212-523-2253

To be completed by MSHH Staff Member
Date of Review: ______________ **Name of Reviewer:** ______________________
Outcome: ______________________________
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