Mount Sinai Health Home

Internal Referral of Patient to Mount Sinai Health Home

Date: __________ Referring Hospital: __________________ Referring Program: _______________

Name Person Making Referral: ____

Phone Number: ________________________ EMAIL:_______________________________________

Patient Demographics	
Patient Name: ____________________________	Patient Date of Birth: __________________________
MSH/MSBI/MSSL MRN: ______________________	Patient Address : ______________________________
Patient Medicaid ID: ________________________	____
Medicaid MCO: ☐ Yes ☐ No	Patient Phone Number:_________________________
MCO Name: ______________________________	

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?			
Is the patient known to a PACT clinic? ☐ YES ☐ NO If yes, where? ☐ GMA ☐ MSSL ☐ IMA			
wĞƚƵƌŶ-ƚŽ-ƚ!/¢ ŏůŝŶŝĐ ůн ŀŘƴĂůă ǌ o 95 ǿĂăĂůă ĂƴĜŝŏŝŘĂƴЭ c Ƴǌƴűƙăű ☐ GMA ☐ MSSL ☐ IMA			

Referrals should be sent via secure, encrypted email to !ůŏĂŀ Ƴǌ, !ŘƳĂƴĂăű-ŭĂǿŝ Coordinator – !ůŏĂŀ-ǌ@mountsinai.org or via fax at 212-523-2253

To be completed by MSHH Staff Member

Date of Review: _______________ Name of Reviewer: ____

Outcome: ____

____