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?

Current Medical/Behavioral Health Care

Location of Primary Care: ☐ MSW ☐ MSSL ☐ MSH ☐ MSBI ☐ Other, Please Specify:

Location of Outpatient Behavioral Health: ☐ MSW ☐ MSSL ☐ MSH ☐ MSBI ☐ Other, Please Specify:

Location of other Specialty Care: ☐ MSW ☐ MSSL ☐ MSH ☐ MSBI ☐ Other, Please Specify:

Referrals should be sent via secure, encrypted email to Joanna Jettoo– Joanna.Jettoo@mountsinai.org or via fax at 646-537-8950