Substance Use Disorder Quality Improvement Project
Case Management Referral Form

Purpose: To facilitate emergency department referrals to CareSource to increase support of our members with substance use disorders (SUD) by engaging them in case management.

Please complete the below form with as much information as you have available. If some of the information is not available, please mark it as N/A. The completed form may be faxed or emailed to the numbers below. Any questions can be directed to the email address listed below.

To: CareSource

Attn: SUD Quality Improvement Project

Fax: **937-396-3027 or**

Email: **INCasemanagement@Caresource.com**

Date: _____

Patient Name: _____

Patient RID #: _____

Patient DOB: _____

Patient Phone #: _____

CareSource confirmed eligibility date: _____

Reason for ED visit:_____

Substance(s) used:_____

Most recent date of use:_____

Length of use:_____

Previous inpatient admits or treatment history:_____

_____

Diagnosis:_____

_____

Current living situation and support system: _____

Referring person: _____

Contact number: _____

Consent to Share Health Information

CareSource believes it is important that you agree to share your health information. This information is shared to handle your care and treatment or to help with benefits. It will be shared with your past, current, and future treating providers. It also will be shared with the Health Information Exchanges (HIE). An HIE lets providers view health information that CareSource has about members. You have the right to ask for a list of everyone who was given your health information by CareSource.

☐ Check this box if you want your health information to be shared with past, current, and future treating providers. The information will be shared for treatment, to manage your care and to help with benefits. Your health information to be shared will include sensitive health information, including treatment for substance use and HIV/AIDS.

Or

☐ Check this box if you **do not want** your health information to be shared with past, current, and future treating providers. The information will not be shared for treatment, to manage your care or to help with benefits. None of your health information will be shared with your providers, with these exceptions:

Due to state requirements we must follow, your Primary Medical Provider (PMP) will receive a report that includes physical and behavioral health treatment information you may have received. It will not include substance use or HIV/AIDS information unless you checked the box above saying you want to share your health information.

Due to other requirements we must follow, your health information will be shared with the HIE. It will not include substance use or HIV/AIDS information unless you checked the box above saying you want to share your health information.

If you do not approve sharing, all providers helping care for you may not be able to manage your care as well as they could if you did approve sharing.

Member Signature: _____

Date: _____