

Medically Fragile Case Management Program

5338 Montgomery Blvd. NE
Albuquerque, NM 87109
505-272-2910 (Metro Office)
505-272-0956 (EFax)
CDD-MedFrag@salud.unm.edu

Medically Fragile Case Management Program Referral

NOTE: THIS FORM CONTAINS PHI. DUE TO HIPAA ENCRYPT PRIOR TO EMAILING.

Email encrypted to CDD-MedFrag@salud.unm.edu or fax to 505-272-0956.

*** Please print. We will be unable to process if illegible. ***

CLIENT INFORMATION			
Date of Referral:	Last Name:	First Name:	
D.O.B.:	Gender: M ☐ F ☐	SSN (required):	
Medicaid: Yes ☐ No ☐	Medicaid ID#:	MCO:	
Medicare: Yes ☐ No ☐	SSI: Yes ☐ No ☐	Private Ins: Yes ☐ No ☐	
		Private Ins Name:	
PRIMARY Diagnosis:		ICD 10 Code:	Primary Physician / Phone Number:
Other Diagnoses / ICD 10 Codes:			
Parent(s) / Guardian(s):		Relationship:	Foster Placement: Yes ☐ No ☐
			Foster Agency Contact:
Mailing Address (include street, city, and zip code):			
Physical Address (include street, city, and zip code):			
Primary Phone Number:		E-mail:	
Alternate Phone Number:			
Primary Language: ☐ English ☐ Spanish ☐ American Sign Language ☐ Other:			
Ethnicity: ☐ Black / African-American ☐ White ☐ Asian ☐ American Indian / Alaska Native			
☐ Native Hawaiian / Other Pacific Islander ☐ Other: ☐ Prefer not to answer			
Is the individual Hispanic or Latino? Yes ☐ No ☐			
Currently Inpatient? Yes ☐ No ☐	Hospital:	Reason for Admission:	
Skilled Care Needs (List below what needs require a skilled nurse in the home)			
Respiratory:			
Neurological:			
Nutrition and Feeding:			
Other Complex Care:			
Impact of I/DD on Ability for Self-Care:			
REFERRAL SOURCE INFO (please complete)			
Referrer's Name:		Facility:	
Phone #:	Fax:	E-mail:	
Pager #:			

PLEASE CONSULT WITH FAMILY PRIOR TO REFERRAL, SO THEY ARE AWARE OF REFERRAL.

For questions about skilled care needs/meeting criteria- please contact:

CDD Main Office - 505-272-2910 / CDD-MedFrag@salud.unm.edu