DIRECT REFERRAL FORM

Referral Date:

REFERRAL SOURCE INFORMATION

Name: ______________________________ Organization: ______________________________

Role: ____

Type: ❑ Health Plan ❑ Provider

Address: ____ City: ____________________________

State: ________ Zip: __________________ Phone: ______________________________________

Email: ____________________________________ Fax: ___________________________________

Alternative Contact Name: ____

Alternative Contact Phone: ____

PATIENT INFORMATION

Name: ______________________________ ICD-10 Code: ___________________________________

Diagnosis: ____

Address: ____ City: ____________________________

State: ________ Zip: __________________ Phone: ______________________________________

Email: ____

Gender: ______________________________ Date of Birth: _________________________________

Age (must be 18 or older): __________________ Preferred Language: _________________________

PCP Name: __________________________ PCP Phone: ________________ PCP Fax: ______________

Specialist Name: __________________ Specialist Phone: ______________ Specialist Fax: ______________

Health Plan: ____

Group Number: ________________ Group Name: ____________________ Member ID: ______________

Location: ❑ Hospital ❑ SNF ❑ Home ❑ Other

Hospital, SNF or Other Location Name (if applicable): ____

Anticipated Discharge Date (if applicable): ____

Anticipated Disposition:

❑ Home with Caregiver Support ❑ Home without Caregiver Support ❑ Home with Home Health
❑ Home with Home Infusion Therapy ❑ Board & Care ❑ Shelter ❑ Other Community Living Situation

PATIENT CLINICAL INFORMATION

Check all that apply:

- ❑ Advanced illness with decline
- ❑ Life expectancy is less than one year
- ❑ Life threatening illness
- ❑ Will participate in advanced care planning
- ❑ Will try in-home or outpatient management prior to using the ED
- ❑ Conditions for which curative treatment is possible, but may fail
  (i.e. Advanced or progressive cancer or complex and severe congenital or acquired heart disease)
- ❑ Conditions requiring intensive long-term treatment aimed at maintaining quality of life
  (i.e. HIV infection, multiple sclerosis or ALS)
- ❑ Progressive conditions for which treatment is exclusively palliative after diagnosis
  (i.e. Advanced dementia or Parkinson disease)
- ❑ Advanced Cancer
  - ❍ Stage III or IV solid organ cancer, lymphoma, or leukemia and
  - ❍ Patient is not tolerating standard treatment and is in need of symptom relief
- ❑ CHF
  - ❍ NYHA class III or IV or hospitalized for CHF with no further invasive interventions planned
- ❑ COPD
  - ❍ FEV1 < 35 % predicted
  - ❍ Gold C or D
- ❑ Dementia
  - ❍ Frequent infections (UTI, pneumonia, etc.)
  - ❍ FAST 5 or higher
- ❑ End Stage Liver Disease
  - ❍ Irreversible liver damage, Albumin < 3.0 and INR 1.3
  - ❍ Ascites, subacute bacterial peritonitis, hepatic encephalopathy, hepatorenal syndrome or recurrent esophageal varices
  - ❍ Evidence of irreversible liver damage and MELD score of > 19
- ❑ End Stage Renal
  - ❍ On Dialysis
  - ❍ GFR 30 or less
- ❑ Other

844-249-5579 (Fax) | referrals@aspirehealthcare.com

Referral Prompted by:

❑ Inadequate home, social or family support

❑ Uncontrolled symptoms related to an underlying disease (i.e. pain, shortness of breath, vomiting)

❑ Recent ER visit or hospitalization caused by destabilization of a chronic condition, and/or overall high utilizer of healthcare services (i.e. multiple ER visits, outpatient services)

Patient Records:

❑ Patient history, medical records, test results, X-rays, etc. attached

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Was the patient or an authorized representative informed of this referral? ❑ Yes ❑ No

Does the patient require an authorized representative? ❑ Yes ❑ No

Patient's Authorized Representative Name: ____

Patient's Authorized Representative Phone: ____

- Aspire Health partners with providers and health plans to provide supportive care to members living with a serious illness or multiple complex conditions.
- The Aspire Health clinical model is based on the concept of "co-management." Aspire's clinical team does not take over a member's care from the PCP and specialists, but instead establishes a partnership with the PCP and specialists to provide an extra layer of support for the member in the member's home.
- An Aspire Health clinician will reach out to a member's PCP or specialist to coordinate any major changes in a member's care plan and will share a one-page summary of the visit with the member's PCP and/or specialist(s).
- Aspire Health offers the member access to a team of clinicians 24 hours a day, 7 days a week.

Upon completion of this form, please send the completed Aspire Direct Referral Form with any pertinent patient medical records, history, test results, etc. via SECURE email to **referrals@aspirehealthcare.com** or fax to **844-249-5579.**

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