Level D Child Referral Form

Instructions: Please complete all fields below as indicated.
Select the appropriate level of care and attach relevant clinical documentation.

UM submission to CareOregon:

1. **Via CIM portal:** (preferred) with completed form and clinicals.
2. **Via fax:** send the completed form and clinicals to 503-416-3713.

Member Client Information

Member legal name: _____

Member preferred name: _____

Member pronouns, if known: _____

Health Share member: ☐ Yes ☐ No Health Share eligibility pending: ☐ Yes ☐ No

Guardian/ Legal representative name:_____ Relationship: _____

Guardian/ Legal representative phone: _____

Member Address: _____

OHP ID: _____ Birth date:_____

Optional: Does the child identify as any of the following (check all that apply, additional space available for specification):

Race:

American Indian/Indigenous/Native American or Alaskan Native*

_____

Asian/Pacific Islander

_____

Black/African American

_____

Eastern European/Russian

_____

Native Hawaiian

_____

Some other race, ethnicity, or origin

White/Caucasian

_____

Chose not to answer

Not provided

Unknown

Ethnicity:

Hispanic, Latino/a/x/e or of Spanish origin

Mexican, Mexican American, Chicano/a/x/e

Puerto Rican

Cuban

Other Hispanic, Latino/a/x/e or Spanish origin

Latino/a/x/e combined with racial identities

Not Hispanic, Latino/a/x/e or of Spanish origin

_____

Immigrant or Refugee:

☐ Yes ☐ No _____

Contacts/Supports

Contact/Support		Phone	Email
	Intensive Care Coordination		
	Wrap Coordinator		
	Regional Care Team		
	Foster parent		
	DHS case worker		
	Other		

Provider Information

Referring provider agency: _____

Primary referral coordination contact: _____

Phone*:_____ Email*: _____ Fax: _____

Preferred delivering provider: _____

**These are required fields.*

Authorization Request Type and Specifics

Level D Child Initial HBS Global (Home-based stabilization)

Level D Child HBS Global - Continued Stay _____

Documentation

Please include the following documentation with initial referral requests.
Check the boxes to indicate which documentation is included.

Required, current and valid assessment that includes:

- Clinical justification for the DSM 5 diagnosis that is a covered diagnosis on Oregon's prioritized list.
- Explanation of the medical need for the services.

Treatment or clinical notes

- When available, 30 days of progress notes are preferred

If applicable or available, recent psychiatric medical provider/medication management notes

Is the child taking medication? ☐ **Yes** ☐ **No** ☐ **Unknown**

If applicable, please list current medications or attach medication list:

_____

☐ Medication list attached.

ER and/or inpatient admissions: ☐ **Yes** ☐ **No** ☐ **Unknown**

If yes, describe the incidents or attach documentation:

Approximate date	Reason for admission

☐ Documentation of hospital incidents included.

Clinical Information

What is the reason for the referral? Please provide the most critical information for understanding the current need for this level of care. This may include risk issues, increasing symptoms, behaviors, and functional impairments.

_____

Current diagnosis(es) (including primary): _____

Known medical conditions: _____

Current level of risk: ◯ Low ◯ Moderate ◯ High

Prominent risk features: suicide attempts, self-harm, harm to others (date, precipitating event, outcome):

Police contacts or OYA involvement:

Are there cultural or linguistic specific needs when considering placement to a team? ◯ Yes ◯ No ◯ Unknown

If yes, please provide summary/details of cultural/linguistic needs for the member and family system as it pertains to treatment and care coordination.

Housing status

Is youth at risk of losing housing? ◯ Yes ◯ No ◯ Unknown

Is youth at risk of losing placement? ◯ Yes ◯ No ◯ Unknown ◯ N/A

Please explain current living situation: