BLUE PLUS / LSS OF MN REFERRAL FORM

CHECK ALL THAT APPLY:

☐ ***LSS HEALTHY TRANSITIONS (Post -Discharge Benefit)***

☐ ***CAREGIVER - EMERGENCY CARE PLAN***

☐ ***MEALS (Post-Discharge Benefit)***

☐ ***FRIENDLY HELPER***

***** CARE COORDINATOR: Complete first page and return to LSS. Include facility discharge paperwork if available for post-discharge benefit*****
Email: LSSHealthytransitions@lssmn.org or FAX# 651-310-9449

MEMBER INFORMATION

Name: _____ DOB: _____

Address: _____ Male ☐ Female ☒ Other ☐

City/State/Zip: _____ Phone: _____

County: _____ Member PMI #: _____

Diagnosis Code(s): _____

To schedule visits, contact: ☐ Client ☐ Emergency Contact ☐ Other: _____

Emergency Contact Name: _____ Relationship: _____

Scheduling Contact Phone: _____

Living Alone: ☐ Yes ☐ No Does member live in a facility? ☐ Yes ☐ No

Note members in skilled nursing facilities do not qualify for post-discharge benefits.

Primary Language: _____ Interpreter Needed: ☐ Yes ☐ No

Interpreter Vendor Name: _____ Preferred Interpreter: _____

HOSPITAL RELEASE INFORMATION ** Required for Post-discharge benefit and LSS Meals **

Estimated Discharge Date from Hospital: _____

Name of Hospital: _____ Phone: _____

AUTHORIZATION INFORMATION

Assigned Care Coordinator: _____ Referral Date: _____

Care Coordinator Phone: _____ Email: _____

SERVICE INFORMATION

Meals - *specify dietary needs*:

For questions about this form, please call 1-888-200-0986.

MEMBER ASSESSMENT

Mobility **LSS Staff are not able to assist with transfers*

- ☐ Ambulatory Alone
- ☐ Ambulatory with Cane
- ☐ Ambulatory with Walker
- ☐ Wheelchair
- ☐ Other: _____

Cognition

- ☐ Alert and oriented
- ☐ Dementia diagnosed
- ☐ Minor confusion at times
- ☐ Other: _____

Social Support **Check which supports member currently receives*

- ☐ Family/Friends
- ☐ PCA/HHA, Homemaker
- ☐ Home care nurse
- ☐ ARHMS Worker
- ☐ Social Worker
- ☐ Other: _____

General Health

- ☐ Vision Loss, due to: _____
- ☐ Hearing Loss
- ☐ Uses Oxygen at Home: _____
- ☐ Portable Oxygen: _____
- ☐ COPD
- ☐ Diabetes
- ☐ Heart Attack Hx: _____
- ☐ Chronic Heart Failure
- ☐ High Blood Pressure
- ☐ Stroke Hx: _____
- ☐ Cancer: _____
- ☐ Anxiety/Depression
- ☐ Smoking: _____
- ☐ Joint Replacement

If applicable, does the member have any upcoming scheduled appointments within 30 days of hospital discharge?

☒ Yes ☐ No **If yes, list any supporting information below*

Does member receive waivered services? ☒ Yes ☐ No

Does the member currently use a meal delivery service? ☐ Yes ☒ No

Additional health information that would be helpful to note for LSS Staff:

Additional notes and recommendations: