CENTER FOR DEVELOPMENT & DISABILITY

Medically Fragile Case Management Program
2300 Menaul NE
Albuquerque, NM 87107
505-272-2910 (Metro Office)
855-280-7504 (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 855-280-7504.
*** 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: **Alternate Phone Number:**	**E-mail:**	
Primary Language: ☐ English ☐ Spanish ☐ American Sign Language ☐ Other: (describe) **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

Revised 4/13/2023