Seton Total Health Partners Referral Form

Name of Person Making Referral: _____

Contact Number: _____

Date of Referral: _____

Reason for Referral: _____

Does patient have complex medical and/or social needs with potential for difficult accessing and/or coordinating necessary outpatient care? ❑ Yes ❑ No

*** If you answered "no" to the above question please contact your case manager instead of referring to Seton Total Health Partners. See acceptance criteria on next page.*

Patient Name: _____

Seton MRN: _____

DOB: _____

County of Residence: ❑ Travis ❑ Hays ❑ Williamson ❑ Other

Funding Source: ❑ Map ❑ Medicaid ❑ Seton Care Plus ❑ Sliding Scale ❑ Charity/Self Pay ❑ Other

Please answer the following questions concerning the patient.

Not all are required for program participation.

Where is the patient currently located? ❑ ED ❑ Inpatient ❑ Outpatient

Has the patient been admitted to a hospital or emergency room 2 or more times within the last 12 months?

❑ Yes ❑ No

Does the patient have any of the following diagnoses?

❑ Wound/Ulcer ❑ Sickle Cell Disease ❑ CHF ❑ Trauma with ICU

Does the patient have 5 or more active medical conditions? ❑ Yes ❑ No

Is the patient currently prescribed 5 or more medications? ❑ Yes ❑ No

Fax completed form to 512-324-7471 or email securely to totalhealthpartners@seton.org

Seton Total Health Partners

Seton Total Health Partners Criteria for Enrollment

Must have all of the following:

- MAP, Medicaid, Seton Care Plus, sliding scale program, or unfunded/self-pay
- Age at least 18
- Travis County Resident
- Complex social and/or medical issues exacerbating current health status
- Sickle Cell, Wounds, Trauma with sequelae, CHF

Need at least one of the following:

- Two or more emergency room visits or hospitalizations in the last 12 months
- High risk for readmission
- Potential for significant cost to the healthcare system

Exclusion criteria:

- History of violence towards caregivers
- Lack of desire to engage in care plan
- Currently in parole program