D H E C
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Best Chance Network
Case Management Intake Form

(Use this form to fax a referral to SC DHEC BCN PA Line 1-866-297-6814)

Last Name: _____ First Name: _____ MI: _____

Address: _____ City: _____ State: _____ Zip: _____ County: _____

SSN#: _____ Patient's Home Phone #: _____

Patient's Work Phone #: _____

Referral Source: **BCN** Referring Facility: _____

Referred by: _____ Phone #: _____
(Person making referral)

Doctor's Name: _____

DOB: _____ Race: _____ Marital Status: _____

Emergency Contact: Name: _____

Relationship to Client: _____ Home Phone #: _____ Work Phone #: _____

Test Results: (Referral to Discipline, Orders)

Results	ICD 9 Code	Date
1. Abnormal Breast Exam	796.4	
2. Mammogram-ACR Code 4 (Suspicious)	793.80	
3. Mammogram-ACR Code 5 (Highly Suggestive Malignancy)	793.89	
4. Breast Ultrasound-ACR Code 4 or 5, Solid Mass	611.72	
5. Fine Needle Cyst Aspiration- a. Indeterminant b. CIS c. Malignant Cells	610.0 233.0 174.9	
6. Pap Smear-Atypical Glandular Cells of Undetermined Significance (AGUS)	795.00	
7. LSIL Pap Smear Low-Grade Squamous Intraepithelial Lesion	795.03	
8. Pap Smear-High Grade SIL (HGSIL)	795.04	
9. Pap Smear-Squamous Cells of Carcinoma/Adenocarcinoma	233.1	
10. Pap Smear-Atypical Squamous Cells of Undetermined Significance-can not exclude High Grade SIL (ASC-H).	795.02	
11. Positive HPV DNA Test. (only if Pap Smear result is Atypical Squamous Cells of Undetermined Significance(ASCUS) - do not refer if Pap result is negative)	795.05	
12. Pelvic Exam-Suspicious for Cervical Cancer	616.0	

Comments:

☐ Missed Follow-Up Appt. ☐ Refused Referral ☐ Unable to Contact ☐ Late Referral for Incomplete Follow-up

Follow-up Referral: Follow-up Facility: _____ Phone #: _____

Purpose of Follow-up Referral: _____ Date of Appointment: _____

Medicaid Coverage Effective Date: _____

Would you like the social worker to contact you before seeing the client? ☐ Yes ☐ No

BCN Staff taking referral: Date:

Instructions for Completing the

Best Chance Network
Case Management Intake Form
DHEC 3714

Purpose: This form is to be used as an intake form for the BCN staff in order to complete a referral for BCN case management services. The case managers will use the form for identifying the reason for the referral and to supply supportive and identifying information. The appropriate district/county staff will also use the form for entering the BCN client in the Novius system.

Item by Item Instructions:
In the first box complete the identifying data for the BCN client being referred for case management services.

In the second box complete the blank for the referring facility (physician's office), enter the name of the person faxing in the referral and the phone number where you can be reached.

In the third box complete the remaining identifying information as requested.

Test Results: Circle the number by the appropriate diagnosis and then give the date the test was completed.

Comments: Give additional information that might help the case manager in providing services for the client.

Mark the appropriate box(s) for the items listed.

Follow-up Referral: Write the name of the follow-up referral facility and phone number. Then complete the reason for the follow-up referral and the date of the appointment.

Medicaid Coverage Effective Date: Complete date that Medicaid is effective if known.

Mark the appropriate box, Yes or No, for request for social worker to contact the referring person prior to seeing the client.

Person Receiving Referral: The appropriate BCN staff receiving the referral needs to sign their name. All referrals must be signed by the staff who receives and processes the referral.

Date: Put the date that the referral was received and faxed to the social worker/case manager.

Office Mechanics and Filing: The original and three copies of this form are kept in different offices. The BCN staff member keeps a copy in a notebook in their office. The Case Management program coordinator housed in Home Health keeps a copy in her office and the BCN Quality Management Coordinator keeps the original in the BCN office. Appropriate personnel will keep all three of these under lock with limited access. These forms will have a retention schedule of one year and should be shredded at the end of that year. A copy of the referral also goes to the appropriate district social worker/case manager. This form should be filed and retained in the clinical record in accordance with standards of the Comprehensive Health Record User's Manual and Home Health guidelines.