

Bridge Case Management Form

New enrollee's name			
Does enrollee receive hemodialysis?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Does enrollee receive peritoneal dialysis?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
If your response is no to both questions above, please do not fill out this form and advance to the Health Risk Assessment.			
Dialysis center name			
Dialysis center address			
	City		ZIP
Dialysis center phone number			
Dialysis Treatment Schedule	<input type="checkbox"/> Monday <input type="checkbox"/> Tuesday <input type="checkbox"/> Wednesday <input type="checkbox"/> Thursday <input type="checkbox"/> Friday <input type="checkbox"/> Saturday <input type="checkbox"/> Sunday <input type="checkbox"/> N/A Time of Treatment: _____		
Does the enrollee need assistance with transportation?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, does enrollee have any special requirements such as wheelchair, gurney, door to door, or curb to curb?	<input type="checkbox"/> Yes <input type="checkbox"/> No Please list:		

In addition to your Nephrologist, what other routine care/providers you see?
 List all that apply: specialists, home health, medical equipment/supplies, etc.
 We will contact them to request that they continue providing care for you.

Name of Provider			
Phone number or address			
Date of next appointment			
Transportation assistance required?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Name of Provider			
Phone number or address			
Date of next appointment			
Transportation assistance required?	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Bridge Case Management Form (Cont.)

Name of Provider	
Phone number or address	
Date of next appointment	
Transportation assistance required?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Name of Provider	
Phone number or address	
Date of next appointment	
Transportation assistance required?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Name of Provider	
Phone number or address	
Date of next appointment	
Transportation assistance required?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Name of Provider	
Phone number or address	
Date of next appointment	
Transportation assistance required?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Name of Provider	
Phone number or address	
Date of next appointment	
Transportation assistance required?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Name of Provider	
Phone number or address	
Date of next appointment	
Transportation assistance required?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Name of Provider	
Phone number or address	
Date of next appointment	
Transportation assistance required?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Name of Provider	
Phone number or address	
Date of next appointment	
Transportation assistance required?	<input type="checkbox"/> Yes <input type="checkbox"/> No