



Member Referral

Instructions: Care Coordinator completes all required fields below and email completed form to orders@grandpad.net;Sarah.a.norquist@HealthPartners.com. Document form submission date and qualifying dx in member case notes.

<input type="checkbox"/>	Member is aware tablet was requested and does want the GrandPad:
<input type="checkbox"/>	Member has diagnosis of Depression or Cognitive Impairment
<input type="checkbox"/>	Member is aware the GrandPad needs to be returned if they dis-enroll from HP MSHO.
Member's Full Name	
If applicable "Preferred Name"	
Member ID Number	
Members Date of Birth	
Member's Primary Language	
Member Phone number	
Member Address Verified with the member for accuracy	
If the above address is a facility or apartment building check appropriate box to explain living situation.	<input type="checkbox"/> Member resides in apartment building <input type="checkbox"/> Member resides in assisted Living. Member resides in Skilled Nursing Facility
Care Coordinator Full Name	
MSHO Intake Phone number	952-883-6983
Care Coordinator Email	
Primary Care Provider Name & Phone Number	
Optional Additional Providers: Include providers name, phone and specialty	
Optional: Are there family members or informal supports that the member would like to call or email regularly? Feel free to add as many as possible! Include person's name, phone and email:	
Additional Information or Notes <i>Include communication barriers, Account Administrator if known.</i>	
Does member have a GrandPad: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure	

To terminate and initiate a return of a GrandPad device, contact GrandPad at: 1-800-704-9412

Email form to:
orders@grandpad.net;Sarah.A.Norquist@HealthPartners.com