

REFERRAL INTAKE SHEET

Referral Date: _____ No current episode Current episode date _____
 Facility/Client# _____ DME
 Client's Name _____ **Referral Source:** **Billing Source:**
 Address _____ Physician Medicare
 City, State, Zip _____ D/C Planner (name) _____ Medicaid
 County _____ Hosp (name) _____ Work Comp
 Phone # _____ Family/Friend/Self Self Pay
 SS# _____ MC# _____ Nursing Home VA

Marital Status: S M D W Does client live alone? Yes No Other _____ Courtesy
 Insurance
Other Individuals/Org. involved in client's care: _____ DDS

Sex	Age	DOB	Allergies	Language Spoken	Emergency Contact (name, phone #, address)
<input type="checkbox"/> New Physician UPIN # _____ <input type="checkbox"/> Licensure Verified Primary Physician _____ Address _____ City, State, Zip _____ Phone # _____ Fax # _____ Primary Dx _____ Secondary Dx's _____ Physician's Orders (include freq., duration, & skilled need) : _____ _____ _____	<input type="checkbox"/> New Physician UPIN # _____ <input type="checkbox"/> Licensure Verified Secondary Physician _____ Phone # _____ Surgery Dx/Date _____ Hospitalized: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other (SNF/Rehab) Admit Date _____ D/C Date _____ Hospital/SNF _____ Work Related: <input type="checkbox"/> Yes <input type="checkbox"/> No				

V.O. Received: _____ SOC Date: _____ Therapy Referred: _____ Part A Part B
 SOC Nurse: _____ Intake Nurse: _____
 RN/Case Mgr. Assigned: _____

Services Requested for **SELF PAY:** SN CHHA PT OT ST MSW Homemaker/Companion
 Frequency, Days, Hours Requested _____
 Other Pertinent Info: _____

BILLING INFO

Policyholder's Name _____	Member ID _____
Policyholder's Employer _____	Policyholder's SS # _____
Insurance Co. _____	Employer's Telephone # _____
Policy/Group # _____	Insurance Plan _____
Benefit Verification Telephone # _____	Group Name _____
Directions to client's home: _____	

Not Accepted For Services Due To: _____ **Referred to:** _____
Referral Source Notified of Negative Referral: _____ **Date:** _____

Upon completion fax this form to 405-634-2079