# REFERRAL INTAKE FORM

**Please fill out form return via**

**fax: 508-802-5587**


Medical Record # _____
Referral Received: Date _____
Time _____ am/pm
Revised Referral Date _____
Type: Admit _____ Re-admit _____ NTUC _____
District _____ Manager _____
Physician Ordered Start Care Date _____
Director Approved _____

## CLIENT DEMOGRAPHIC INFORMATION

Last Name _____ First Name _____ MI ____

Address _____ Floor/Apt # _____

City _____ Zip _____ Tel# _____ DOB _____ Age _____ ■ M ■ F

Language ■ English ■ Spanish ■ French ■ Russian ■ Other _____

Emergency Contact _____ Relationship _____

Address/City/ZIP _____ Tel# _____

Guardianship *(specify type if known)* _____ Name of Guardian _____

Address/City/ZIP _____ Tel# _____

## INSURANCE INFORMATION

Dual Insurance _____ PCC needed Y / N ABN needed Y / N ASAP Form Y / N

SS # _____ Medicare# _____

Medicaid# _____ PCC Group _____

Other Insurance (specify) _____

## REFERRAL INFORMATION

Reason for Referral _____

Referring MD/Hospital/Other _____ Person Referring _____ Tel# _____

Hospital Admission Date _____ Reason for Hospitalization _____ Discharge Date _____

MD who will follow Client _____ Tel# _____

Other MD _____ Tel# _____

## CLINICAL INFORMATION

Medical Diagnoses _____

_____

Client and Family Aware of Dx Y / N Surgical Dx/Date _____ ■ Early Episode ■ Late Episode

Past Medical History _____

Hx of Behavioral/Safety Risk _____

Medications _____

Insulin/IV's/Injections (freq) _____

Allergies _____

Other Significant information _____

## PHYSICIAN'S ORDERS

Nursing ____ PT ____ OT ____ SLP ____ SW ____ HHA ____ LAB Work needed _____

Referral Form Completed By _____ Requested Discharge Summary to be Faxed (____) _____