Referral Intake Form

Referral Source: _____ ❑ Institutional ❑ Community

Referral Phone: _____ Referral Date: _____

❑ Facility stay in the 14 days prior to SOC date If so, what type of facility: _____ ❑ Inpatient ❑ Outpatient

Episode Timing: ❑ Early ❑ Late Discharge Facility: _____ DC Date: _____

Referring Physician: _____ Phone: _____

Primary Physician: _____ Phone: _____

Payor: ❑ Medicare ❑ Private Insurance ❑ Workers Compensation ❑ Medicare Advantage _____

MBI #: _____ Medicaid #: _____

Eligibility Checked: ❑ Yes ❑ No ❑ See attached verification sheet

Intake Staff Name: _____

Intake Staff Signature: _____ Date: _____

Referral Accepted: _____ Referral Declined Due To: _____

Additional Information Needed: _____

Assigned To: _____ H&P/DC Summary Attached: ❑ Yes ❑ No

Patient/Client Name: _____

Address: _____

City, State, Zip: _____ Phone: _____

Sex: ❑ Male ❑ Female Race: _____ DOB: _____ Marital Status: ❑ M ❑ S ❑ W ❑ D

Emergency Contact: _____

Relationship: _____ Phone: _____

Emergency Contact: _____

Relationship: _____ Phone: _____

Authorized Representative(s): _____ Phone: _____

Advance Directives: _____ Code Status:_____ Health Care Decision Form(s) Requested: ❑ Yes ❑ No

Language(s) patient/client understands: _____ Language(s) representative understands: _____

F2F Encounter Date: _____ Reason for Encounter: _____

OR F2F Encounter Scheduled Date: _____ Visit Note Attached: _____

Primary Dx: _____ Date of Onset/Exacerbation: _____

Comorbidities: _____ Date of Onset/Exacerbation: _____

Services Requested: Specify discipline, frequency/duration, treatments ❑ No ancillary services needed at this time

❑ SN Freq. _____ ❑ Contacted ❑ HHA Freq._____ ❑ Contacted

❑ PT Freq. _____ ❑ Contacted ❑ OT Freq. _____ ❑Contacted

❑ ST Freq. _____ ❑ Contacted ❑ MSW Freq. _____ ❑ Contacted