KINGSPOINT HEALTHCARE SERVICES INC
10900 KINGSPOINT RD, SUITE 10; HOUSTON, TX 77075
PHONE: (713) 378-4488 / FAX: (713) 378-4477

PATIENT/CLIENT REFERRAL

Referral Source: ____ ❑ Institutional ❑ Community

❑ Inpatient ❑ Outpatient

Referral Phone:____________________________ Referral Date: ________________________________
Referring Physician: ___________________________________ Phone: ___________________________
Primary Physician: ___________________________________ NPI: _________________________

Phone: ____________________ Fax_________________________________

Address:____
City, State, Zip: _____________________________________

PATIENT INFORMATION:

Patient/Client Name: ____
Address:____
City, State, Zip: _____________________________________ Phone: ______________________________
Sex: ❑ Male ❑ Female Race: _________________________ DOB: ______________________

Marital Status: ❑ M ❑ S ❑ W ❑ D

Language(s) patient/client understands: _______________________

Primary Insurance: ❑ Medicare ❑ Private Insurance ❑ Workers Compensation ❑ Medicare Advantage
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MBI #: ________________________ Medicaid #: _______________________________________

SSN: ________________________

CLINICAL DATA:

Primary Dx: ____

Date of Onset/Exacerbation: ____

Comorbidities: ____

Date of Onset/Exacerbation: ____

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I certify that, based on my findings, the following services are medically necessary home care services the patient requires for clinical improvement and/or patient/care-giver ability to learn. *(Please check all that apply and include a brief narrative describing the clinical justification of this need)*

□ **SKILLED NURSING:** related to illness, exacerbation or injury:

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□ **PHYSICAL THERAPY:** related to illness, exacerbation or injury:

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□ **OCCUPATIONAL THERAPY:** related to illness, exacerbation or injury:

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□ **SPEECH THERAPY:** related to illness, exacerbation or injury:

____

My clinical findings support the need for the above services because:

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Print Name   Physician Signature   Date