

# 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