# REFFERAL FORM

Cornerstone Healthcare Systems

Please fill out form
Fax:774-243-6531
Phone:774-243-6555

Medical Record #:____________________
Referral Received: Date____________________
Time____________ am/pm
Revised Referral Date____________________
Type: Admit_____ Re-admit_____ NTUC_____
Physician order start care date: __________
Director Approved______________________

## CLIENT DEMOGRAPHIC INFORMATION

Last Name________________________________ First Name ________________________________MI

Address ____________________________________________________ floor/Apt#______________

City__________________________ Zip __________ Tel ____________________DOB ________________M☐ F☐

Language ☐ English ☐ Spanish ☐ 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 Vs Injections (freq) ______________________________________________________

Allergies________________________________________________________________________

Other Significant information:______________________________________________________

## PHYSICIAN'S ORDERS

Nursing____ PT_____ OT_____ SLP_____SW_____ HHA ______

Referral Form completed by:__________________________ Requested Discharge Summary to be Faxed______________________