INTAKE/REFERRAL FORM

Date: ______________________ Referred by: ____________________________ Contact#: _________________________

Patient Name: ____ DOB: _____________ Sex: **MALE** **FEMALE**

Address: ____
Street Address City State Zip

Tel #: ____ Alt #: ____

Patient Lives in: **HOME** **ASSISTED LIVING** **NURSING FACILITY** **OTHER**: ___________________________

Height: _____________ Weight: _____________ Diagnosis: _________ __________ _________ __________

Emergency Contact Name: _____________________________________ Tel #: ___________________________________

Next of Kin (closest relative not living with patient): _____________________________ Tel #:___________________________

Dates of Admission and Discharge: Hospital ________________________ Skilled Nursing Home ______________________

Is patient Diabetic? **YES** **NO** If yes: **TYPE I** **TYPE II**

PHYSICIAN INFORMATION:

______ PCP _____ ORDERING NPI# ____________________________________

NAME: _______________________________________ TEL# _________________________ FAX # ______________________

ADDRESS: ____
Street Address City State Zip

INSURANCE INFORMATION:

Primary: ____ ID#: ________________________________

Secondary: ____ ID#: _________________________________

Tertiary: ____ ID#: _________________________________

Does Carrier require Prior Authorization? **YES** **NO**

Is condition related to an accident? If yes, what type? ____

Patient meets Eligibility requirements?
Check if requirement has been determined met:

☐ **Valid Rx** ☐ **Completed CMN (signed and dated)**

☐ **Chart Notes (legible)** ☐ **Completed Intake Form**

COMMENTS: