

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