MedSource
Health Care System

Fax Patient Referral Form

Fax: 972-572-9782
Tel: 972-572-9783
Toll free: 1-888-572-9783

Patient Name:

_____, _____ ____
Last Name First MI

Address:_____
_____

Patient discharged from:
☐ Hospital ☐ Rehab
☐ Nursing Home ☐ Other_____
Discharged: __/__/____

Phone:( )- _ _ _ - _ _ _ _ or ( )- _ _ _ - _ _ _ _

Insurance:

☐ Medicare # _____
☐ Medicaid # _____
☐ Primary Insurance:
Policy #:_____
Others:_____

DOB: _ _ / _ _ / _ _ _ _ **SEX:** ☐ M ☐ F

Age:_____
Marital Status: ☐ S ☐ M ☐ D ☐ W
HIC # : _____
SS # : _ _ _ - _ _ - _ _ _ _

Referring Physician:_____
Phone:( ) - _ _ _ - _ _ _ _ **UPIN#:**_____
Address:_____
Fax #: ( ) - _ _ _ - _ _ _ _
Primary MD _____
Phone:( ) - _ _ _ - _ _ _ _ **UPIN#:**_____
Fax #: ( ) - _ _ _ - _ _ _ _

Allergies:_____
☐ NKDA

Emergency Contact Name:
_____
Relationship:_____
Phone: ( ) - _ _ _ - _ _ _ _
Alternate Contact:_____
Phone: ( ) - _ _ _ - _ _ _ _

Disciplines Ordered:

SN	**PT**	**OT**
☐ Eval and Treat	☐ Eval and Treat	☐ Eval and Treat
☐ Eval Only	☐ Eval Only	☐ Eval Only

ST
☐ Eval and Treat ☐ **HHA** ☐ **MSW**
☐ Eval Only ☐ Eval

Others:_____

DME Needed:
☐ Oxygen ☐ Wheelchair ☐ BSC
☐ Bed ☐ Walker ☐ Cane ☐ Nebulizer
☐ Other:_____

DIAGNOSIS **DATE**
1._____/_____
2._____/_____
3._____/_____
4._____/_____
5._____

Skilled Care Orders:_____
_____
_____

Professional Staff Signature_____ **Date** _____