REFERRAL FORM

BRANCH: LYNN LAWRENCE BRIGHTON/QUINCY **SITE: MCHC LAWRENCE BRIGHTON/QUINCY**

SOC / ROC: / /_____ ADMIT READMIT RESUMPTION

PATIENT INFORMATION

Last Name: **First Name:**

Address: **City:** **Zip:**

Phone: **Language:**

DOB: / / Social Security #

Emergency Contact: **Phone:**

Relationship:

Does Patient Live Alone: Yes No **Gender M F**

INSURANCE INFORMATION

Primary: **Policy #:**

Secondary: **Policy#:**

Case Manager:

Phone #: **Fax #:**

Authorization #:

Authorization Dates: / / to / /

Insurance Verified: Yes No Initials: Date:

REFERRAL INFORMATION

Referral Source:

Admission Date: / / Discharge Date: / /

Person Referring: **Phone:**
Fax:

Previous Inpatient Facility:

Admission Date: / / Discharge Date: / /

PCP: **Phone:**
(Confirmed) Y N (Pecos Enrolled) Y N

Surgeon /Other: **Phone:**
(Confirmed) Y N (Pecos Enrolled) Y N
Medicare Face-to-Face Encounter Form received from Referral Source ☐
MD Follow Up Appointment Scheduled Y N Appt. Date: / /
Discharge Paperwork to be Faxed Y N Patient to be sent home with copy Y N

DIAGNOSIS INFORMATION

Primary Dx: **ICD9 CODE:**

Secondary Dx: **ICD9 CODE:**

Procedure Dx: **ICD9 CODE:**

PMH:

Allergies:

SERVICES ORDERED

SN PT OT SLP PSYCH MSW Assess for HHA
SPECIFIC ORDERS

OTHER PERTINENT INFORMATION

ASSISTIVE DEVICE:

DME Vendor:

Vendor Contact:

Vendor Phone:

Lab Draws:

Additional Information:

Referral Taken by: **Date: / / Time:**

Revised: 8/18/11

PLEASE FAX TO: (781)593-7169