Your First Choice
Affinity
Home Health Care

REFFERAL FORM

Date of Referral _____ Time _____

AHHC Intake Person _____ Referred By _____

Contact Person _____ Phone _____

CLIENT INFORMATION

Client/Patient Name _____ DOB _____ Sex _____

Address _____ Phone _____

City/State/Zip Code _____ Client/PT'S SS# _____

Client/Pt's Medicare # _____ Medicaid# _____ (Optional)

Spouse SS# _____ (Optional) Other _____

Emergency Conatct _____ Phone _____

Address/ City ST/ Zip Code _____ Relationship _____

MD INFORMATION

Physician Name _____ Phone _____

Address _____ City/ST/ Zip Code _____

Fax _____ UPIN# _____ Speciality _____

PRIVATE/SECONDARY INSURANCE INFORMATION

Private Ins. CO _____ Phone _____

Address/ City/ST/ Zip _____ (Optional) Effective Date _____

Certification/Policy # _____ Group# _____

OTHER

Principal Diagnoses _____ (list)

DME/Supplies needed _____ Supplier's Phone # _____

Approved by RN Supervisor _____ RN Case Manager _____

Date Approved _____ Date Assigned _____

Notified MD ☐ RN ☐ LVN ☐ PT ☐ HHA ☐ MSW ☐ OT ☐ ST ☐ OTHER ☐