

Approved for Admit by: \_\_\_\_\_

**IPH HEALTHCARE  
REFERRAL FORM**

HQI Ck by: \_\_\_\_\_  
A \_\_\_\_\_ B \_\_\_\_\_ NA

(Please indicate patient need) **Home Health: Yes or No** **Hospice: Yes or No**

Date of Referral: \_\_\_\_\_ Time: \_\_\_\_\_ Taken By: \_\_\_\_\_  
Admission Date: \_\_\_\_\_ Admission Assigned To: \_\_\_\_\_  
Assigned CM: \_\_\_\_\_ MR: \_\_\_\_\_

**PERSONAL INFORMATION**

Patient Name (Last, First, MI) \_\_\_\_\_ Phone # \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M \_\_\_ F \_\_\_ Primary Language: \_\_\_\_\_  
Address: (Street, City, Zip) \_\_\_\_\_  
Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone #: \_\_\_\_\_  
Caregiver Name: \_\_\_\_\_ Phone #: \_\_\_\_\_ Caregiver able and willing to assist? \_\_\_yes \_\_\_no

**INSURANCE INFORMATION**

Medicare #: \_\_\_\_\_ Medicaid # \_\_\_\_\_ Social Security #: \_\_\_\_\_  
Insurance Company: \_\_\_\_\_ Type of Insurance: \_\_\_Private \_\_\_Medicare HMO \_\_\_Medicaid HMO \_\_\_Other  
Group # \_\_\_\_\_ ID# \_\_\_\_\_ Authorization #: \_\_\_\_\_  
Contact Person: \_\_\_\_\_ Phone #: \_\_\_\_\_

**MEDICAL INFORMATION**

Ordering Physician: \_\_\_\_\_ NPI# \_\_\_\_\_ TX License #: \_\_\_\_\_  
Will Sign 485 orders? \_\_\_yes \_\_\_no If no, find out who will. \_\_\_PCP \_\_\_Other \_\_\_\_\_  
Address: (street, city, zip) \_\_\_\_\_ Phone # \_\_\_\_\_ Fax #: \_\_\_\_\_  
Recent Hospitalization: \_\_\_No \_\_\_Yes Date of Admit: \_\_\_\_\_ Date of D/C: \_\_\_\_\_  
Hospital Name: \_\_\_\_\_ Phone # \_\_\_\_\_  
Primary Diagnosis: \_\_\_\_\_ ICD-9 Code: \_\_\_\_\_  
Other Diagnosis: \_\_\_\_\_ Code: \_\_\_\_\_ Other Diagnosis: \_\_\_\_\_ Code: \_\_\_\_\_  
Date: \_\_\_\_\_ Activity: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Allergies: \_\_\_\_\_

Medications: \_\_\_\_\_  
Treatment/Frequency: \_\_\_\_\_

Significant Information: \_\_\_\_\_

**OTHER INFORMATION**

DME Order: \_\_\_\_\_ DME Vendor: \_\_\_\_\_ Phone # \_\_\_\_\_  
Referred By: \_\_\_\_\_ Institution: \_\_\_\_\_ Phone # \_\_\_\_\_  
Admitting Clinician Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Outcome of Referral:  Admit  Non-Admit REASON: \_\_\_\_\_

**\*\*Fax this form to: 979-848-2028**

REFERRAL FORM

revised 08/08