CareMate Home Health Care, Inc
2236 Marshall Ave
(651) 659-0208
Fax: (651) 659-0161

Intake Referral

Spend down
Yes ___ No ___

Per:
C.M. ______
Client ______

Referral Taken By:________________ Referral Source: ____________________ Date: __________ Time: __________

Patient Name: ____ M ( ) F ( ) Age: _______ DOB: ______________

Billing Source: ______________________________________ SSN: ______________________________

PMI No: ______________________ Medicare No: ______________________ HMO No: __________________

Address: ____ Phone: ______________________________

City: ______________________________ County: ______________________ State: _____ Zip: ___________

Emergency Contact: __________________________ Relationship: _______________ Phone: ______________

Address: ____ Business Phone: ________________

Legally Responsible Party: ________________________________ RP ___ POA ___

Person Calling: ____________________________________ Phone: ______________________________

Relationship to Client: ________________________

Case Manager: ______________________________________ Phone: ______________________________

Financial Worker: ___________________________________ Phone: ______________________________

Primary Diagnosis: ____ Date of Onset: ________________

Secondary Diagnosis: ____ Date of Onset: ________________

Patient aware of Diagnosis: Y ( ) N ( ) Recent Surgery: _____________________________________ Date:_________

Primary
Physician: ____ Specialty: ______________________________

NPI # _________________ Clinic: ________________ Phone: __________________ Fax: ________________

Address: ____________________________________ City: _____________________ State: ____ Zip: _________

Hospital: _____________________________________ Admit: ______________ Discharge: ______________

Patient lives with: Spouse ( ) Relative ( ) Alone ( ) Others ( )

Requested Services: ____

____

____

Additional Information:____

____

Other Services Received and From Where: ____

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REV 9/24/2014