BMHHC-2012

REFERRAL FORM

BLUE MOUNTAIN HOME HEALTH CARE, INC.

Physician's Office: Please complete and Fax back to: 570-622-4465

PATIENT NAME: _____

ADDRESS: _____

_____

PHONE: _____

EMERGENCY CONTACT: _____

CONTACT PHONE: _____

DATE OF BIRTH: _____

MEDICARE NUMBER: _____

MEDICAID NUMBER: _____

OTHER INSURANCE: _____

_____

REFERRED BY: _____

PRIMARY PHYSICIAN: _____

PRIMARY DIAGNOSES: _____

_____

OTHER DIAGNOSES: _____

_____

ADMISSION PRIORITY:

□ TODAY

□ WITHIN 48 HR

□ DATE:_____

TREATMENT:

□ SKILLED NURSING □ PHYSICALTHERAPY

□ OCCUPATIONAL THERAPY □ MEDICAL SOCIAL SERVICE

□ HOME HEALTH AIDE

SPECIFIC ORDERS:

□ LAB DRAW (SPECIFY) □ ASSESS AND INSTRUCT

□ WOUND CARE (SPECIFY) MEDICATIONS

SPECIFY: _____

_____

REFERRAL/ PHYSICIAN SIGNATURE: _____

DATE COMPLETED: _____

Please provide an office contact name and phone below. BMHHC Intake coordinator will confirm receipt of this referral:

NAME: _____ PHONE: _____

WE LOOK FORWARD TO SERVING YOU AND YOUR PATIENTS

1851 W End Ave, Suite A, Pottsville, PA 17901 Phone: 570-622-4444 Fax: 570-622-4465 Toll Free: 800-932-6615