TENDER HEART HOME HEALTH
REFERRAL INTAKE FORM

Referral Source_____ **Phone**_____-_____
Referral taken by Veronica Wilkins OM Referral Date __/____/_____ **SOC Date** ___/____/_____
Non-admit reason: **Referral Contact Made:**

CLIENT INFORMATION: DOB _____/____/_____ **EARLY EPISODE** _____ **LATE EPISODE** _____
Client: Last _____ First _____ M____ ☐ Male Female
Address_____ Phone _____-_____SS# _____
City _____ State, TEXAS Zip _____County: _____
Diagnosis: _____

Referring Physician _____NPI_____
UPIN _____LIC _____Phone_____-_____-_____ Fax _____-_____-_____
Physician Address _____City _____State TEXAS Zip _____
PCP_____NIP_____
UPIN_____LIC_____Phone_____-_____Fax_____-_____-_____
Physician Address _____City_____ State TEXAS Zip _____
Emerg.Contact/relationship: _____Phone_____-_____
Contact made _____Comments _____

ORDERS & DISCIPLINE ASSIGNMENT
☐RN _____Date _____ ☐ LVN _____Date _____ ☐HHA _____Date_____
☐PT_____Date_____ ☐OT_____Date_____ ☐ST_____Date_____ ☐MSW_____Date_____
Orders:_____
LAB ORDERS _____ **RN** _____
DME/INFUSION Company _____Phone_____
ALLERGIES:_____ HT:_____WT_____
DME NEEDED/Company_____ Phone: _____Ordered: ☐Yes ☐ No

INSURANCE: ☐ MCR ☐ MCD ☐ MCR HMO ☐SEC HOR ☐ BCBS ☐ UHC ☐ TRI CARE ☐ JPS ☐ P.PAY ☐ MASH

Primary: _____ **Secondary:** _____
MCR/MCD/INS.# _____ **MCR/MCD/INS**_____
Main. Phone # _____ Precert. Phone #_____