THREE RIVERS HOME HEALTH
INTAKE REFERRAL

Please print referral form and fax to (478) 374-3423

DATE: ________________ REFERRAL SOURCE: ______________________________________

REFERRAL SOURCE PHONE NUMBER: _______________________

NAME. ____

DOB: ______________________ M F PHONE NO: __________________

ADDRESS: ____

EMERGENCY CONTACT: _______________________________ PHONE NO: __________________

PHYSICIAN: ____ PHONE NO: __________________

ADDRESS: ____

MEDICARE: ______________________________ MEDICAID: _____________________________

INSURANCE: ____________________________________ INS PHONE #: ___________________

INSURED NAME: ________________________ POLICY # / GROUP #: _______________________

SOCIAL SECURITY NO: ____

DIAGNOSIS: PRINCIPLE DX: ____

SURGICAL: ____

SECONDARY DX ____

OTHER ____

____

ORDERS: ____

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HOSPITAL STAY: __________________ ADM. DATE: ___________ D/C DATE: ____________

ANY PREVIOUS HOME HEALTH ____YES ____ NO WHERE: ___________________________

DIRECTIONS: ____

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OFFICE USE ONLY

OASIS ELIGIBILITY: OASIS INELIGIBLE (MARK ONLY IF UNDER 18 OR PREGNANT)

REFERRAL TAKEN BY: ____

ASSESS FOR HHS: ______________________________ ADMITTED / NOT ADMITTED

NOTICE: ***Three Rivers Home Health Services, Inc. will fully consider the patient for admission, however, this does not guarantee the patient admission by the agency.***