BROOKS HEALTH CARE

Proudly serving the people and communities of Central California

PHONE #: 1-877-889-3424 FAX#: 1-877-832-6022

PATIENT REFERRAL FORM

***PLEASE ATTACH: H&P and Labs**

Date:_____

Home Health Agency:_____

Payer:_____ Group Number:_____

Subscriber ID #: _____ Subscriber Name:_____

Medicare #:_____ Medi-Cal #:_____

Patient:_____ DOB:_____ Sex:_____

SSN:_____ ☐ **Attached Copy of Insurance Card**

Address:_____

Phone #._____ Emergency Contact:_____

Allergies:_____ H**t:**_____ **Wt:**_____

Current Medications:_____

Diagnosis:_____

Medication_____ Dose:_____ Frequency:_____

Therapy Start Date:_____ Duration of Therapy: _____

IV Access: ☐ PICC ☐ Central ☐ IM ☐ Heplock (Peripheral IV)

☐ Homecare skilled nursing for administration and teaching

Referred By: _____

Physician Name:_____ Date:_____

Physician Signature:_____ Phone#:_____

Physician Address:_____

License#:_____ UPIN:_____ DEA#:_____