americare®
a tradition of caring

REFERRAL REQUEST FOR HOME CARE SERVICES

Intake: 718-535-3100, ext. 3247
Fax: 718-234-4178
If urgent, please call 917-992-5529

Patient Name: _____ Telephone: (____) _____ – _____

Address: _____ City _____ State ____ Zip ____

Date of birth: ____ / ____ / ____ Social Security Number: _____ – _____ – _____

Pt Emergency Contact: _____ Telephone: (____) _____ – _____

Pt's Living Arrangement: _____

Insurance: Medicare #: _____ Medicaid #: _____

Other Insurance/HMO #: _____

Authorization #: _____

Physician Name: _____ Telephone: (____) _____ – _____

Address: _____ City _____ State ____ Zip ____

License #: _____ NPI #: _____

Pt Diagnoses: **Date:**

1. _____ ____ / ____ / ____
2. _____ ____ / ____ / ____
3. _____ ____ / ____ / ____
4. _____ ____ / ____ / ____

Ambulation Status: _____ **Mental Status:** _____

Allergies: _____ **Diet:** _____

Recent hospitalization – if applicable – (where): _____ Date: ____ / ____ / ____

Reason for home care: _____

Medications (name, dosage, route, frequency)**:**

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

SERVICES REQUESTED: ☐ RN ☐ PT ☐ OT ☐ HHA ☐ MSW

MD Signature Here: X _____ Date: ____ / ____ / ____