NEW PATIENT REFERRAL FORM

Community Liaison: Kelly Liberato
Phone: 267-443-0067
Fax: 855-252-4442
Email: kliberato@visitingphysicians.com

PATIENT NAME *(LAST)*:_____ *(FIRST)*:_____ *(MI)*: _____

RESIDING ADDRESS: _____ **APT / BLDG #:** _____

CITY:_____ **STATE:**_____ **ZIP:**_____

NAME OF FACILITY: _____ *AFC/ALF* ☐

PATIENT PHONE:_____ **IS THIS THE NUMBER TO CALL WHEN MAKING APPTS?:** ❑ *YES* ❑ *NO*

PATIENT EMAIL: _____ **TELEHEALTH CAPABLE:** ❑ *YES* ❑ *NO* ☐ **PHONE OR** ☐ **COMPUTER**

SSN:_____ **DATE OF BIRTH:**_____ **GENDER:** ❑ *MALE* ❑ *FEMALE*

MARITAL STATUS: ❑ *SINGLE* ❑ *MARRIED* ❑ *WIDOWED* ❑ *DIVORCED* **RACE:** _____ **ETHNICITY:** _____

LANGUAGE: _____ **IS THE PATIENT A VETERAN?** ❑ *YES* ❑ *NO*

EMERGENCY CONTACT NAME/REL: _____ **PHONE:**_____

DOES THE PATIENT HAVE A POA / GUARDIAN: ❑ *YES* ❑ *NO (SKIP SECTION)* **LEGAL STATUS:** ☐ *POA(FIN)* *POA(MED)* ❑ *GUARDIAN*

NAME:_____ **RELATIONSHIP:** _____

BILLING ADDRESS:_____ **APT / BLDG #:** _____

CITY:_____ **STATE:**_____ **ZIP:**_____

POA / GUARDIAN PHONE:_____ **NOTIFY BEFORE EACH VISIT:** ❑ *YES* ❑ *NO*

PATIENT DIAGNOSIS/HEALTH ISSUES: _____

SPECIAL VISIT INSTRUCTIONS AND ALLERGIES: _____

IS THE PATIENT LATEX SENSITIVE: ☐ *YES* *NO* **IS THE PATIENT CURRENTLY BEING TREATED BY A PRIMARY PHYS:** ❑ *YES* ❑ *NO*

IS THE PATIENT CURRENTLY ON OR RECEIVING: ❑ *HOSPICE* ❑ *HOME CARE* ❑ *PRIVATE DUTY* ❑ *OTHER:* _____

IF YES, NAME OF AGENCY PROVIDING SERVICES:_____ **PHONE:** _____

HOW DID THE PATIENT HEAR ABOUT OUR SERVICES: ❑ *WORD OF MOUTH* ❑ *HHA* ❑ *AFC/ALF* ❑ *MARKETING* ❑ *OTHER*

REFERRING PARTY:_____ **PHONE:** _____

COMMUNITY LIAISON NAME: _____ **PHONE:** _____

PRIMARY INSURANCE CARRIER NAME: _____ ❑ *HMO* ❑ *PPO*

INSURANCE ID NUMBER (MBI NUMBER IF MEDICARE): _____ **GROUP NUMBER:** _____

EFFECTIVE DATE: _____ **INSURANCE PHONE:**_____

SECONDARY INSURANCE CARRIER NAME: _____ ❑ *HMO* ❑ *PPO*

INSURANCE ID NUMBER (MBI NUMBER IF MEDICARE):_____ **GROUP NUMBER:** _____

EFFECTIVE DATE: _____ **INSURANCE PHONE:**_____