USA DOCTORS ON WHEELS
WE VISIT BECAUSE WE CARE
375 Municipal Drive Suite 218 Richardson Texas
Tel No: (469)-453-1423 E.Fax: (469)-453-1436

PATIENT REFERRAL FORM

REFERRING HOME HEALTH

Home Health: _____Date: _____

Contact Person: _____ Phone: _____

Contact Email: _____Fax: _____

PATIENT'S INFORMATION

*Last Name: _____ First: _____ M.I. _____

*DOB: _____/_____/_____ *Gender: _____F _____M *Phone: _____

SSN: _____ *Medicare Number: _____

*Address: _____*City: _____

*Zip Code: _____ *Building Number: _____ *Apartment Number: _____

*Alternate Contact: _____ Phone: _____ Relationship: _____

Origin the Patient being referred: ____ Discharged from Hospital ____ Other Home Health

MEDICAL HISTORY

*Diagnosis: _____

*Allergies: _____

*Pharmacy Name: _____ *Phone: _____

*Address: _____*Zip Code: _____

INSURANCE INFORMATION

*Primary: _____ *Secondary: _____

(Please attach copy of Medicare and other Insurance cards.)

*Referral Signature: _____ *Today's Date: _____

***IMPORTANT**: Together with this form, please attach a copy of Medical Records, Medical History, and Medication Records.

I certify that the following information provided is accurate and true.

I authorize USADOW to use the information to provide medical necessities to my patient.

ACCREDITED BUSINESS
BBB Rating: A+

USA Doctors On Wheels is Better Business Bureau (BBB) accredited.

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