



REFERRAL FORM

Please fill out the following ConfiCare Referral Form and fax to **(561) 392-9008**. Please include as much information as possible to expedite the referral process. Do not hesitate to call **(888) 994-6660** if you have any questions. A ConfiCare representative will contact you shortly after submission. Thank you for your referral!

<i>Demographics: Patient Name and Information</i>					
Last Name:		First Name:			
Address:					
City:		State:	Zip:		County:
Phone:			Alt. Phone:		
SSN:	DOB:	Age:	Race:		
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female		Anticipate Start Date:			
<i>Referral/Hospital Information</i>					
Referral Source:					
Address:					
City:		State:	Zip:	Email:	
Phone Number		Ex:	Fax Number:		
From which of the following inpatient facilities was the patient last discharged?					
Hospital Name:					
Address:					
City:		State:		Zip:	
Admit date:		M0180-Discharge Date:			
Referred by:			Phone:	Ex:	
Beeper:		Fax Number:			
e-mail:		M0190 Inpatient Facility Diagnosis:			

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Contact Name				
Last:	Suffix:	First:	Initial:	
Address:				
City:		State:	Zip:	
Home Phone:		Office Phone:		Ex:
Relationship:				
Comment (please list any additional contacts if necessary):				
Primary Physician				
Last:	Suffix:	First:	Initial:	
Address:				
City:		State:	Zip:	
Office Phone:		Ex:	Beeper/Cell:	
E-mail:		Specialty:		
UPIN:		License:	Expiration:	
Comment (please list contact info on consulting physician if applicable):				
Diagnosis/Orders/Meds				
Allergies			Pharmacy	Evaluations
NKA	Penicillin	Codeine	Tape	<input type="checkbox"/> SN <input type="checkbox"/> PT <input type="checkbox"/> OT <input type="checkbox"/> ST <input type="checkbox"/> MSW
ASA	Other			
Medical Diagnosis:			Surgical Diagnosis:	

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Orders:						
Medication	Dose	Unit	Route	Frequency	PRN	Comments
Insurance Information						
Payment Source:						
Medicare #:	Part A	Part B	Source of Admission:			
Insurance/HMO Name:						
Policy #:	Group #:		Plan # / ID#:			
Coverage Start:			Coverage End:			
Services Covered:						

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