



85 Bartlett Street, Brooklyn, NY 11206
 Phone: (718) 387-8181
 Fax: (718) 782-1538

PATIENT REFERRAL INFORMATION

REFERRAL INFORMATION		
Referring Institution/Agency/Individual:		
Referred contact phone: () -	Referral Method:	
Referral Status/Priorities:		
Referral Date:	Requested Visit Date:	Release Date and Time:
PHYSICIAN PROVIDING ORDERS		
Physician Name:	Phone: () -	Fax: () -
UPIN:	NPI:	License Number:
PATIENT INFORMATION		
Last Name:	First Name:	Phone: () -
Service Address:		Zip Code:
DOB: / /	SEX:	Marital Status:
Social Security Number:		Language Spoken:
Language Understood:		Lives With:
Pets:		
INFORMAL CAREGIVER INFORMATION		
Name:	Relationship:	Home Phone() - Work Phone() -
Address:	Age:	Days/Hours Available:
Caregiver Participation in Plan? Willing Able	Learn Essential Treatments Willing Able	
EMERGENCY CONTACT INFORMATION		
Name:	Relationship:	Home Phone() - Work Phone() -
Address:	Age:	Days/Hours Available:
Caregiver Participation in Plan? Willing Able	Learn Essential Treatments Willing Able	
HOUSEHOLD ROSTER		
Age:	Relation:	TB S/S
Back-up Caregiver Agreement: (Include copy of agreement if available)		
Services requested: please circle (RN, HHA, PT, OT, ST, MSW)		
IN-PATIENT INFORMATION		
Last Stay facility:	Floor/Unit::	Phone() -
Admission Date:	Discharge Date:	
MEDICAL SUPERVISION AT HOME		
Responsible Physician/Clinic:	Responsible Physician/Clinic:	
Physician/Clinic Address:	Phone: () -	Fax: () -
Next Appointment Date:	Clinic Contact Person/Title:	
Clinic Physician/UPIN:		
Secondary Physician/Clinic:	License Number/Clinic Address:	
Phone: () -	Fax: () -	
Other Physician/Clinic:	License Number/Clinic/UPIN:	
ADVANCE DIRECTIVES INFORMATION		
Health Care Proxy Name:	Health Care Proxy Address:	
Home Phone() -	Work Phone() -	
Relationship:		
Living Will:	DNR Request:	

PATIENT REFERRAL INFORMATION cont.

OTHER AGENCIES PROVIDING SERVICE			
Agency Name:	Contact person:	Phone: ()	-
Services Provided:			
Durable Medical Equipment:	Vendor:	Phone: ()	-
Supplies:	Vendor:	Phone: ()	-
INSURANCE INFORMATION SUMMARY			
Medicaid Number:	EMEVS Aid Category:	Approved date:	Recert Date:
Medicare HIC Number:	Medicare Coverage Codes:		
Other Insurance Codes:			
Sex:	Year of Birth:	Office Code:	EMEVS Eligibility date:
Previsit Documentation: (Any special instructions)			
<p>Patient Information summary <i>Ex.....85 yo male, lives with wife, 2nd floor walk up, no elevator; hx of dementia, HTN. Need meds management, daily wound care, RN eval, P.T. eval and HHA. Has both Medicare /Medicaid.</i></p>			
Meds as ff: (List all meds on DC)			

FOR DISCHARGE REFERRALS NEEDING HOME CARE:

- a. Call: **Mercy Barias at 718-387-8181 ext 116 or 347-235-9117**
Rosa Kremer at 718-387-8181 ext 118 or 347-853-9797
Sharon Rosen at 718-387-8181 ext 128
Patrice Miller, Intake Nurse at 347-678-3460
- b. Email mbarias@whiteglovecare.com or rkremer@whiteglovecare.com
- c. Or fax this referral form to 718-782-1538