Patient Referral Form

For Physicians, Hospitals, SNFs, ALFs & Referring Facilities

REFERRING PROVIDER / FACILITY INFORMATION

Referring Provider Name: _____ **NPI:** _____

Facility / Practice Name: _____

Address: _____ **City / State / ZIP:** _____

Phone: _____ **Fax:** _____

Contact Person: _____ **Email:** _____

PATIENT INFORMATION

Patient Full Name: _____ **Date of Birth:** _____

Address: _____ **City / State / ZIP:** _____

Phone (Primary): _____ **Phone (Secondary):** _____

Emergency Contact Name: _____ **Emergency Contact Phone:** _____

Primary Insurance: _____ **Member / Policy ID:** _____

Secondary Insurance: _____ **Member / Policy ID:** _____

REASON FOR REFERRAL

- ■ Visiting Physician Services (home / facility rounding)
- ■ Advanced Wound Care
- ■ Post-Hospital Discharge Follow-Up
- ■ Chronic Disease Management (Diabetes, CHF, COPD, etc.)
- ■ Medication Reconciliation / Polypharmacy Review
- ■ Concierge Medicine / Direct Physician Access

■ Remote Patient Monitoring

■ IV Hydration / Infusion Therapy

■ Hospice Physician Support

■ Lab Testing at Home

■ Other: _____

CLINICAL NOTES / PERTINENT HISTORY

_____
_____
_____
_____

CURRENT MEDICATIONS (attach list if available)

_____
_____

ALLERGIES

_____

Signature: _____ **Date:** _____

Printed Name: _____ **Relationship:** _____

Fax completed form to: 210-251-4912 | **Call:** 210-251-4911 | **Email:** contact@primevitalityhealth.com
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