

Intake Staff \_\_\_\_\_ New Horizon Enterprises Date \_\_\_\_\_  
Office Phone: 203.456.0320 Fax Number: 203.889.4948 (Call to confirm receipt of faxed referral)

INTAKE REFERRAL FORM - Request for Services

Referral Source/ Person making referral: \_\_\_\_\_ Requested Start of Care Date \_\_\_\_\_

Type of Service Requested \_\_\_\_\_

Case Manager \_\_\_\_\_ Agency \_\_\_\_\_

Phone # \_\_\_\_\_ Fax: \_\_\_\_\_

Payor Source/Program: \_\_\_\_\_ Authorization #: \_\_\_\_\_

Services Requested (please circle): PCA COMP HMK ILST RA

Please fax: ISP, History, Service Hours, Discharge Medications/Instructions Most Current (only), MD,s, and Rehab Notes.

Client- Name: \_\_\_\_\_ D.O.B. \_\_\_\_\_ SEX \_\_\_\_\_ SSN \_\_\_\_\_

Home Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Principal Diagnosis & date: \_\_\_\_\_

Other Diagnoses & dates: \_\_\_\_\_

Surgical Procedures & dates: \_\_\_\_\_

Last Physician Appointment date: \_\_\_\_\_ Was appointment related to reason for home care referral?  Yes  No.

Primary Physician: \_\_\_\_\_ Phone: \_\_\_\_\_ NPI#: \_\_\_\_\_

Health Insurance Information: Medicare#: \_\_\_\_\_ Medicaid# \_\_\_\_\_

Other Health Insurance: \_\_\_\_\_ Policy# \_\_\_\_\_ Group# \_\_\_\_\_

Medications: \_\_\_\_\_

Last Flu Vaccine: \_\_\_\_\_ Last Pneumonia Vaccine: \_\_\_\_\_ Would you like these vaccines?: \_\_\_\_\_

Allergies: \_\_\_\_\_ Diet: \_\_\_\_\_

Home Environment: House \_\_\_\_\_ Apt/Flr. \_\_\_\_\_ Lives Alone \_\_\_\_\_ Smokes \_\_\_\_\_ Pets \_\_\_\_\_ Drives \_\_\_\_\_

Behaviors: \_\_\_\_\_

Restrictions: \_\_\_\_\_

Functional Limitations:  Amputation  Speech/Hearing  Legally Blind  
 Limited Manual Dexterity  Cognitive Impairment

This referral will be evaluated to determine if client meets NHE Admission Policy-We will contact you with date we may begin service.

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