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.