



ME MEDICAL GROUP, APC

We Excel in Patient Centered Care

PATIENT REFERRAL FORM

Phone: 951-418-1670 | 818-459-2646

SECURE FAX: 888-459-5615

Email: admin@memedicalgroup.com

1. PATIENT INFORMATION

First name *

Last name *

Date of birth (MM/DD/YYYY) *

Street address *

Apt/Unit

City *

State *

ZIP code *

Patient phone *

Preferred language

Caregiver / responsible party

Caregiver phone

2. INSURANCE INFORMATION

Primary insurance plan *

Member / Medicare ID *

Group number

Secondary insurance plan

Secondary member ID

Insurance phone

Do not enter a Social Security number. Attach or fax insurance cards when available.

3. REFERRING AGENCY / SOURCE

Agency / facility name *

Referring person and title *

Direct phone *

Fax

Secure business email

Referral date (MM/DD/YYYY) *

Preferred callback time

Urgency *



Routine



Urgent



Time-sensitive



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CLINICAL REFERRAL DETAILS

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4. REQUESTED SERVICE

- | | | |
|---|--|--|
| ☐ Primary care home visit | ☐ Telehealth visit | ☐ Post-hospital follow-up / TCM |
| ☐ Medicare Annual Wellness Visit | ☐ Chronic disease management | ☐ Wound evaluation |
| ☐ Medication review | ☐ Home health face-to-face evaluation | ☐ Other |

5. MEDICAL REASON FOR REFERRAL

Primary diagnosis / reason for referral *

Additional diagnoses / pertinent history

Recent hospital/SNF and discharge date

Current PCP / attending provider

Symptoms, mobility/homebound status, precautions, and special instructions

6. RECORDS BEING SENT BY SECURE FAX

- | | | |
|---|---|---|
| ☐ Face sheet | ☐ Insurance cards | ☐ History and physical |
| ☐ Discharge summary | ☐ Medication list | ☐ Home health orders |
| ☐ Laboratory / imaging reports | ☐ Patient authorization, if required | ☐ Other |

FAX CLINICAL RECORDS TO: 888-459-5615

Include this completed form as the first page. Do not email unencrypted patient records.

7. REFERRER ATTESTATION

I confirm that I am authorized to submit this referral and accompanying records for treatment, payment, or healthcare operations. The information provided is accurate to the best of my knowledge. This form is not monitored for emergencies; call 911 for emergencies.

☐ I agree to the attestation above.

Typed name / signature *

Date (MM/DD/YYYY) *