# Referral Form

**Date: _____**

**Patient Name: _____**
***first*** ***last*** ***middle initial***

**Patient DOB:_____/_____/_____ Gender _____**

**Patient Address: _____**

**Location Type: _Assisted Living ___ Skilled Nursing Facility ___ Home**

**Facility Name: _____Phone: _____**

**Fax: _____ Email: _____**

**Patient Status: Hospice Home Health Other_____**

**Name of Service Company: _____**
**Case Manager Name: _____**

**Entry date of last Hospitalization: _____ Discharge Date: _____**

**Hospital Name: _____**

**Diabetic: Yes__ Type 1__ Type 2__ Number of Wounds: ____**

**Location(s) of wound(s): _____**
**Duration: _____**

**Diagnosis Code(s): _____**

**Referring Agency:** _____

**PCP:** _____

**Phone:** _____

**Fax:** _____ **Email:** _____

**How did you hear about us:** _____

**Emergency Contact:**

**Name:** _____ **Relationship:**_____

**Phone:** _____ **Email:**_____

**Insurance Information:**

**Primary Insurance:** _____

**Subscriber Number:** _____

**Secondary Insurance:** _____

**Subscriber number:** _____

**SSN:** _____

**PHARMACY INFORMATION**

**Pharmacy Name:** _____

**Address:** _____

**Phone:** _____

**IMPORTANT**

**To expedite intake, please attach the following:**

- Copy of insurance card(s)
- Face Sheet
- Medication List
- H&P

EMAIL: intake@gentlecare.health

www.gentlecare.health