

Check One: Intermittent
 Private Duty

Awakened Alternatives, Inc.
PATIENT REFERRAL

Office Information:

Date/Time Received: _____ SOC: _____ Patient ID#: _____
Admitting RN: _____ New Admit Readmit Person Assigned _____ Date _____

Patient Information:

Name _____ DOB (mm/dd/yyyy) _____ Age _____
Address _____ Apt. # _____ City/Zip _____ County _____
Telephone: (____) _____ SSN: _____ - _____ - _____ Sex (circle one): **M** **F**
Patient Lives: Alone w/Spouse Other _____ Marital Status (circle one): Single Married Divorced Widowed Separated
Emergency Contact: _____ City _____ Telephone: (____) _____
Relationship to Patient: _____

Referring Entity Name: _____

How did you hear about us? _____

Hospital/Nursing Home/Agency/Other (if applicable): _____

Date Patient Admitted (mm/dd/yyyy) _____ Date Patient Discharged (mm/dd/yyyy): _____

Name of Referral Caller: _____ Referrer's Telephone: (____) _____

Physician Information: Name (first & last) _____ Hospital Affiliation _____

Medical Information: Primary Diagnosis: _____

Secondary Diagnosis: _____

Medications: _____ Labs: _____

Allergies: _____ Diet: _____ DNR Status: _____

DME Supplies: _____ Date to be ordered: _____ DME Company: _____

Service/instructions (include frequencies): RN/LPN HHA PT OT ST MSW _____

Billing Information (check one):

- Medicare HIC# _____
- Public Aid Case # _____ Recipient # _____ Exp. Date: _____
- Private Ins. ID # _____ Group # _____ Phone: (____) _____
- Other _____