60 Katona Drive - Suite 18, Fairfield, CT 06824
Tel (203) 256-1804 / Fax (203) 259-8523
Toll Free 1-888-811-1110
www.shamrockhomecare.com

REFERRAL FORM FOR HOME CARE SERVICES

Please fill in the appropriate information and fax to us at 203-259-8523

Patient's Name: ______________________________ **Date of Birth:** ______________

Patient's Address: ___________________________ **Patient's Phone #:** ______________

Primary Contact person/ Emergency Contact: ___________________ **Phone#** ___________

Referring Physician: ______________________________________**Phone#** _____________

Primary Care Physician: __________________________________ **Phone#** _____________

Insurance (***including ID # or include a photocopy of ID card if possible***):

☐Medicare ☐Medicaid ☐SWCAA *(S.W.Connecticut Agency on Aging)*
☐Private Pay ☐Aetna ☐Connecticare ☐Anthem Blue Cross/Blue Shield
☐Private Insurance ☐United Healthcare ☐CIGNA Healthcare
☐Assurant Health ☐Great-West (*now part of CIGNA*) ☐Gentiva Carecentrix
☐Beech Street/Viant ☐Coventry National Network/First Health ☐Other___________
☐Long Term Care Policy (specify company) ___________________

Diagnosis & Medical History*(include ICD-9 Code if possible)*:

☐401.9 HTN ☐250.00 DM ☐428.0 CHF ☐ 331.0 & 294.10 Alzheimer's Disease w/Dementia
☐414.00 CAD ☐530.81 GERD ☐496 COPD ☐781.2 Abnormality of Gait
☐707.22 Stage 2 Pressure Ulcer ☐707.05 Pressure Ulcer-Buttock ☐707.07 Pressure Ulcer-Heel

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Patient requires the following services **(please specify frequency & duration)**

☐ **Skilled Nursing** ☐ **Physical Therapy** ☐ **Occupational Therapy**
☐ **Social Worker** ☐ **Home Health Aide**

Current Medications & **Allergies** ____

Drug	Dose	Freq./Route		Drug	Dose	Freq./Route

Diet: ____

Comments: ____

____

Wound Care: ____

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Physician Signature ________________________**Date:** ___________