PARA//EL
home care services

PATIENT REFERRAL FORM

Date: _____

Referring Agency/Department:_____ Phone:_____

Referral Contact Person:_____ Signature:_____

Primary Reason for Referral:_____

Patient Information:

Name:_____ DOB:_____ Male _____ Female_____

Phone:_____ Alternate Phone if any:_____

Address (where services are to be provided):

Street:_____

City:_____ State:_____ Zip:_____

Emergency Contact:_____ Relationship:_____

Phone:_____ Alternate phone if any:_____

Primary Physician: _____ Phone:_____

Requested Services:

- ☐ Skilled Nursing
- ☐ Physical Therapy
- ☐ Occupational Therapy
- ☐ Speech Therapy
- ☐ Home Health Aide
- ☐ Social Work

Information to be faxed with Referral:
Demographics/Insurance Info_____ Medications List_____ H & P_____ Office Note_____

Thank you for this referral!
Please return this completed document via fax to 906-273-1021 or email to
info@parallelhomecare.com
Call 906-273-1169 with any questions.