REFERRAL FORM

☐ 2-Later **M0110:** □ 1–Early ■ NA (Private Pt) ALLSTAR HEALTHCARE, INC. TRANSFER FROM ANOTHER HHA: 1100 W. Pioneer Parkway ■ Beneficiary Elected Transfer Agreement needs to be completed. Arlington, TX 76013 NOTIFY Transfer Agency by Phone Tel: 817-461-3341 Fax: 817-795-7074 Document notification on OASIS Narrative (M0010) Agency Medicare Provider Number: 679001 (M0020) Patient ID Number: (M0040) Patient Name: (Suffix) (M0066) Birth Date: ______ (M0069) Gender: □ Male □ Female Pt Tel #: _____ Address: City (M0050) State (M0060) Zip Code Fax: ALF / ILF Name: _____ Marital Status: ☐ Single (M0064) Social Security No: ____ ■ Married □ Divorced ■ UK – Unknown or Not Available ■ Separated ■ Widowed ■ Unknown _____ (M0065) Medicaid Number: _ (M0063) Medicare No: ■ NA – No Medicare □ NA – No Medicaid Emergency Contact: _____ ☐ Spouse ☐ Son ☐ Daughter ☐ Friend ☐ POA ☐ Other Relationship: Home Phone: Cell Phone: Work Tel: __ prior to admission Tel #: (M0018) National Provider Identifier (NPI) for the attending physician who has signed the plan of care: Face to Face Encounter Documented: Yes – Date: ______by____ Form faxed to Physician: Yes (IF PATIENT CANNOT BE ADMITTED WITHIN 48 HOURS OR POSTPONED. PHYSICIAN MUST BE NOTIFIED) (M1000) Referral Source: Tel: Fax: Patient D.C. from: _____ From_____ to:____ (Specify if Rehab) _____ fo:____ Name of Former Facility: :_ (If within the last 14 days of admission) Current Problems/Diagnosis: _____ ☐ Wound Care ☐ Lab ☐ Other: Additional Orders: **Discipline Needed:** □ RN _____ □ P.T.___ □ O.T. ____ □ S.T. □ HHA □ MSW □ WOCN Name of Adm. Agent: □ RN □ P.T. □ S.T. to assess and admit patient to home health services & perform complete physical assessment. 485 with orders, frequency, duration and goals to follow. (M0104) SOC/ROC – (RN/Therapist Receiving Order): Order Date Update – If Applicable (RN/Therapist Receiving Order): ______ Date: _____