TRIMED
Home Care Services

Serving Brooklyn, Queens, Bronx, Richmond, New York City, Nassau & Suffolk

PH: (516) 218-2700 info@trimedhomecare.com FAX: (516) 569-0722

REFERRAL REQUEST FOR HOME CARE SERVICES

Please call if you have any questions or need more information. To make a referral, please fill out this form as completely as possible and **fax to: 1-516-569-0722 or call us at (516) 218-2700**

REQUIRED INFORMATION

Name of Patient: _____ Phone: _____

Is this patient aware of this referral? ( ) Yes ( ) No Language: _____

Referred by: _____ Referrer Phone:_____

Organization: _____ Date of Referral: _____

PATIENT INFORMATION

Patient Address: _____

Date of Birth: _____ SS#: _____ Gender: ❑M ❑F Marital Status: ❑S ❑M ❑W

Current Location: ❑Home ❑Alone ❑with family ❑Nursing Facility ❑Hospital ❑Other: _____

Medicaid Status: ❑Eligible # _____ ❑May be eligible ❑Medicare # _____

Other Insurance #: _____ Authorization needed: ❑Yes ❑No

Authorization # (if available): _____

FAMILY/CAREGIVER CONTACT INFORMATION

Name: _____ Relationship to patient: _____

Address (if available): _____

Phone (if available): _____

REASON FOR REFERRAL

- Chronic conditions ( ) Yes ( ) No _____
- Disabilities ( ) Yes ( ) No _____
- Requires assistance ( ) Yes ( ) No (e.g. skilled nursing, home care, personal care)

Primary Diagnosis: _____

_____

What is the patient requesting? : _____

Is patient currently receiving home care services? : ❑ Yes ❑ No ❑ Do not know ❑Start date_____

If known, please specify service, provider and contact information including phone & contact person: _____

_____

PATIENT'S PRIMARY CARE PHYSICIAN

Name: _____ Signature: _____

Address: _____ Phone:_____