Avery Cares Health Services LLC

Fax: (214) 774-8480 | Email: referrals@averycares.org | Phone: (678) 425-7448

Patient Intake Referral Form

Please complete and return this form via email or fax. Our team will follow up within 24 business hours. At Avery Cares, every client is seen, cared for, and treated like family.

Section 1: Patient Information

Full Name: _____ **Date of Birth:** _____

Gender (circle one): Male / Female **Phone Number:** _____

Address (where care is needed_____ **City:** _____ **Zip:**_____

Insurance (if applicable): Carrier_____ Policy Number_____ Group Number_____

Section 2: Referring Physician's Information

Referring Physician's Name: _____ **Facility/Practice Name:**_____

Phone Number: _____ **Fax:** _____ **Email:** _____

Section 3: Reason for Referral & Services Requested

Primary Reason for Referral: _____

Requested Services (check all that apply):

[ ] Skilled Nursing [ ] Home Health Aide [ ] Enteral Feeding [ ] Post-Surgery Care [ ] Wound Care [ ] Other Functional Needs(Dementia, Incontinence, IADL, list any other)

_____

Section 4: Medical Information *(Fax any Relevant Medical Reports and Prescriptions)*

Primary Diagnosis (ICD-10 Code): _____ **Relevant Medical History**:_____

Allergies: Yes [ ] No [ ] If yes, kindly list: _____

List of Current Medications (attach if needed): _____

Fall Risk: Yes [ ] No [ ] **Advance Directive/DNR on File:** Yes [ ] No [ ]

Preferred Start Date/Care hours: _____

Additional Notes (Pets in the home, language preferences, specific routine):_____

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Section 5: Emergency Contact / Primary Caregiver

Name: _____ Relationship to Patient: _____

Phone Number: _____ Email (optional): _____

Section 6: Submission & Signature

Signature of Referring Physician: _____ Date: _____

Thank you for the referral!