Modern Medical House Calls

Office: 817-912-1771
Fax: 940-241-6156

Email: MODMEDHC@GMAIL.COM
Website: MODMEDHC.COM

PATIENT REFERRAL FORM

Referral Source: _____ Date: ____/_____/_____

Contact Name: _____Telephone: ____-_____-_____ Fax: _____-_____-_____

PATIENT INFORMATION

Patient Name:_____ DOB: _____/_____/_____

Marital Status: ☐ M ☐ S SSN: _____/_____/_____ Sex: ☐ M ☐ F

Phone Number: _____-_____-_____ Alt #:_____-_____-_____

Address:_____ _____, _____ _____

Street City State Zip Code

Apt: _____ Building _____ Facility Name _____

Race: ☐ Black ☐ Caucasian ☐ Spanish ☐ Asian ☐ Other

Language Preference: ☐ English ☐ Spanish ☐ Other

Emergency Contact:_____ Phone: _____-_____- _____

Relationship: _____

Second Emergency Contact (if needed): _____

MEDICAL INFORMATION

Diagnosis History: **(Please Attach)** RX List: **(Please Attach)**

Does the patient have a PCP: ☐ Y ☐ N Name of PCP: _____

Most Recent place of Dr. visit or Hospital:_____

Is patient on dialysis? ☐ Y ☐ N If yes – What Days: ☐ **MWF** ☐ **TRS**

INSURANCE INFO

Medicare ID: _____ Secondary Ins ID: _____

Preferred Pharmacy: _____ Cross Street: _____

Pharmacy Phone: _____-_____-_____ Fax: _____-_____-_____

Referral Signature: _____ Date: _____/_____/_____

Office Use Only:

☐ MC Eligible ☐ Information Verified ☐ Patient Contacted ☐ Patient Scheduled☐ NP Letter Sent

Part B Start Date_____ G0438/G0439 Date_____