Office Referral Form
Customer Service / Intake

McLaren
HOMECARE GROUP

Phone: (866) 323-5974
Fax: (866) 571-9636

❑ See included face sheet for below demographic information

Patient Name: ______________________________

Requested 1st Visit Date: ______________ Discharge Date: ______________

Patient Address/City/Zip: ______________________________

Patient Phone(s): ______________________________

Emergency Contact Name & Phone: ______________________________

Patient Insurance Policy & Number: ______________________________

Social Security Number: __________ DOB: __________ Last Office Visit: __________

Allergies: ______________________________

Referring Physician Name: ______________________________

Referral Source: ______________________________

Requested Services		Special Programs		
❑ Nursing	❑ Occupational Therapy	❑ ADaPT (Palliative Care)	❑ Hospice	❑ Home Infusion
❑ Physical Therapy	❑ Medical Social Worker	❑ Heart Failure	❑ COPD	❑ Tele-Health Program
❑ Speech Therapy	❑ Dietician	❑ Senior Sight (low vision)	❑ Maximum Mobility (fall prevention)	
❑ Home Health Aide		❑ Joint Express at Home/Joint Replacement	❑ Lifeline	
		❑ Stroke Care	❑ Lifeline Plan of Care	❑ Nutrition Care

Diagnosis: ______________________________

Surgery / Date: ______________________________

Additional Information / Notes

❑ H & P	❑ Recent Chest X-ray	❑ PT/OT Notes
❑ Face Sheet	❑ Recent Labs	❑ Diet
❑ Discharge Order	❑ Current med list	❑ Wound Care Orders

PT/INR:	Next Lab Draw:
Primary Care Physician / Phone / Fax	485 Signing Physician / Phone / Fax ❑ Standing Order

Nurse Signature ______________________________ Date __________

Physician Signature ______________________________ Date __________

(Rev. 12/2014)