LIV HEALTH

REFERRAL FORM

Please fax to: Wyoming Office: 307.632.3298 | Colorado Office: 970.372.6412

Referring Agency/Provider: _____ Phone: _____

Email: _____ Today's Date: _____

Reason for Referral: ☐ Care Management ☐ In-Home Counseling ☐ Both

Please include the following with the referral when available:

☐ Demographic Sheet ☐ History and Physical (H&P) ☐ Discharge Summary

Patient Information:

First Name: _____ Last Name: _____ Initial: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____ DOB: _____

Email Address: _____

Primary Insurance: _____

Secondary Insurance: _____

Diagnosis 1: _____ Diagnosis 2: _____ Diagnosis 3: _____

Is patient currently receiving home care or other service? ☐ Yes ☐ No If yes, please explain _____

_____

_____

Is patient ambulatory? ☐ Yes ☐ No Number of people living in the home _____ ☐ Not Sure

Does patient smoke? ☐ Yes ☐ No

Does patient own guns or other weapons? ☐ Yes ☐ No ☐ Not Sure

Does the patient have any history of violence? ☐ No ☐ Yes If yes, please explain _____

_____

_____

Does patient have pets? ☐ Yes ☐ No ☐ Not Sure

Please inform patient that dangerous animals must be place in secure area.

Does patient have a religious preference? ☐ Yes _____ ☐ No

Emergency Contact: _____ Phone: _____

Next of Kin: _____ Phone: _____

Additional Information: _____

_____

_____