



REFERRAL FORM

Please fax to: Wyoming Office: 307.632.3298 | Colorado Office: 970.372.6412
Find our referral form online at livhealth.org/forms

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: _____

WYOMING OFFICE

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COLORADO OFFICE

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