

## EXPRESS REFERRAL FORM

**ALERT** Your patient's admittance into our care will be delayed if fields are left incomplete or required forms are not attached.

### Muskegon

#### Referral Required Information

Complete this form, gather required documentation and fax to:

▶ **866-260-1432**

Thank you for your partnership in ensuring swift patient care.

Name \_\_\_\_\_ Date \_\_\_\_\_

Company \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_

Email address if available \_\_\_\_\_

#### Required Documentation

**Please Attach:**

- Demographic sheet, including insurance information
- H & P (including secondary diagnoses/comorbidities)
- Physician signature (on this form or on attached physician order)
- Progress notes
- Current medication list

**Also Required For Referrals From Skilled Nursing Facilities**

- Admission/Anticipated Discharge Dates
- Facility Discharge Summary

### COMPLETE THE FOLLOWING FIELDS ONLY IF THE INFORMATION DOES NOT ALREADY APPEAR IN THE ATTACHED DOCUMENTATION.

#### Patient Information

Patient's name \_\_\_\_\_

D.O.B. \_\_\_\_\_ Phone \_\_\_\_\_

Email address if available \_\_\_\_\_

Has the patient been discharged from a facility in the last 14 days? Y N

Facility name \_\_\_\_\_ Dates \_\_\_\_\_

Physician to Follow in the Community  
(First & Last Name Required, Address & Telephone Number if Available)

\_\_\_\_\_

#### Ordered By (Physician, NP or PA):

Printed Name

\_\_\_\_\_

Signature

\_\_\_\_\_

Date

\_\_\_\_\_

Or:  
Verbal Order from

\_\_\_\_\_

Obtained by (Printed Name)

\_\_\_\_\_

Signature

\_\_\_\_\_

Date

\_\_\_\_\_

#### Services Requested

Palliative Care

Home Care

- Nursing  PT  OT  Speech Language Pathology
- Social Work  Wound Care  Infusion  Home Health Aide