York Healthcare
"Your Health Our Care"

Referral Date: _____

Referred By: _____

Contact #: _____

Referral Form
Fax to: 347-368-4828 or Call: 718-460-4200

Patient Information:

Full Name: _____ DOB: _____

Address: _____ City: _____

State: _____ Zip Code: _____ Primary language: _____

Home Phone #: _____ Mobile Phone #: _____

Gender: ☐ Male ☐ Female Social Security #:_____

Current Location: ☐ Home ☐ Nursing Facility ☐ Hospital ☐ Other: _____

Medicaid #: _____ Medicare #: _____

Does the patient want to apply for Medicaid? ☐ Yes ☐ No

Other Insurance: _____

Primary Physician: _____ Phone #: _____ Fax: _____

Address: _____ City: _____

State: _____ Zip Code: _____ LIC #: _____

Emergency Contact Information

Name: _____ Relationship to Patient: _____

Address: _____ Contact #: _____

Reason for Referral:

Client has difficulty with the following:

☐ Bathing ☐ Cooking ☐ Dressing ☐Housekeeping ☐ Shopping ☐ Toileting ☐ Vision ☐ Walking

Please list any medical problems the client is experiencing:

_____

_____

Is patient aware of referral? ☐ YES ☐ NO

Is patient receiving homecare services? ☐ YES ☐ No ☐ Don't know If known, please specify service provider and contact information: _____

Additional Information:

_____

_____