Gateway Medical

Referral Form

Referral Date________________________________ High Rehospitalization Risk ☐ Yes ☐ No

Referral Source/Practice____________________________Contact Phone # __________________________

If you are not attaching Patient Demographic information, please complete the following information

Patient Name ______________________________DOB (mm/dd/yy)_________________ ☐ Male ☐ Female

Street Address ____Phone #____________________________

City _________________________ State_______ Zip_____________SS#___________________________

Emergency Contact ______________________Relationship _____________Phone #___________________

Height __________Weight __________Allergies ____

Primary Care Physician ____________________Last Appointment_____________Next ________________

Diagnosis _____________________________ Diabetic Status ☐ Type I ☐ Type II ☐ Hemoglobin A1c ☐ N/A

Medicare # _________________________________Medicaid # __________________________________

Other Insurance: _______________________Policy # ____________________Group # ______________

Physicians Orders: OT/MSW/HHA must accompany orders for SN/PT and or/ST

Requested Start of Care date (if no date given SOC will be within 48 hours) ______________________

Disciplines Ordered: ☐ SN ☐ PT ☐ OT ☐ ST ☐ SW ☐ HHA

DME: ☐ YES ☐ NO (list items) _____________________________ ☐ Labs (attach complete order)

☐ Wound Care Orders (Specify)____ OR

☐ Cleanse with wound cleanser or saline, apply wet to dry normal saline dressing, cover with dry gauze, secure with tape daily x 3 days or until MD provides updated orders. **Call back to (Name/Telephone)** _____________________

____

☐ Home Infusion Provider Name _____________________________ Phone # ____________________

Length of Need ______________ First Dose ☐ Yes ☐ No Date and Time Next Dose Due ____________

Type of Line ______________ # of Lumens __________ Date Placed __________Location _____________

Physician Signature (or Copy of MD Order) _________________________________ Date ________________

Physician Full Name (Print) ____NPI # _________________

I certify that my clinical findings support that this patient is homebound and in need of the above services.

Verbal order ____Date _________________

Complete Referral Includes: (referrals without the following information cannot be processed in a timely manner)

1. Demographics/ Insurance	2. Orders (use above if signed by MD)
3. History & Physical / Discharge Summary/Medication List	4. Face to Face (F2F)/MD office note(s)

PO Box 2169 • Lexington, SC 29071-2169 • Phone (803) 358-8496 • Fax (866) 614-3887

GatewayCares.com