LIFE OPTIONS HEALTH SERVICES, INC.

4001 W. DEVON AVE. SUITE 409 CHICAGO, IL 60646

TEL: 773-628-7499 FAX: 773-647-1394

REFERRAL FORM

(M0104) Referral Date: _____ (M00300) Start of Care Date: _____

(M0102) DATE OF PHYSICIAN-ORDERED START OF CARE (RESUMPTION OF CARE):_____

Patient Name: _____MR#_____SSN: _____

Address: _____

DOB: _____ Telephone: _____ Gender: ☐ Female ☐ Male

Emergency Contact: _____ Relationship: _____

Address: _____Telephone: _____

MD Name: _____ NPI: _____

Telephone: _____ Fax # _____

Address: _____

Payment Source:

☐ Medicare: ☐ Part A: _____ ☐ Part B: _____

☐Medicaid: _____ Case ID # _____ Others: _____

☐Private Insurance: _____ Case Manager: _____ Telephone: _____

Referral Source:

☐ Hospital: _____ Hosp. Date: _____ DC Date: _____

☐ Nursing Home/Rehabilitation Facility: _____ DC Date: _____

☐ Transfer from Other Agency: _____ Clinic / Doctor / Home Visit

☐ Others: _____

Required Services:

☐RN: _____ ☐ OT: _____

☐HHA: _____ ☐ ST: _____

☐PT: _____ ☐ MSW: _____

☐Others: _____

Diagnosis: _____

Referral taken by: _____Date:_____