DIAMOND
HOUSE CALLS

NEW PATIENT REFERRAL

Referral Source Information

Who is Making the Referral? ❑Self ❑Family ❑Home Health Agency ❑Hospital ❑Social Worker ❑Other: ____________________

Name: ____ **Phone Number**: ____________________________

Fax Number: ________________________ **Email**: ____

Reason for Referral: ❑Establish Primary Care ❑Hospital/Rehab Transitional Care ❑Sick Visit ❑Specialty Care: ______________

Patient Information

Patient Name: ____ **DOB**: ________________ **Sex**: ❑ M ❑ F

Driver's License State & #: __________________________________ **SSN #**: ________________________________

Home Phone: ___________________________________ **Cell Phone**: ____________________________________

Address: ____________________________________ **City**: __________________ **State**: ______ **Zip**: ___________

❑Home ❑Apartment ❑Assisted Living ❑Group Home **Name of Facility/APT**: ______________________________________

Marital Status: ❑Married ❑ Single ❑Divorced ❑Widowed **Email**: ____

Pertinent Medical History: ❑HTN ❑HLD ❑Diabetes ❑MI/CAD ❑Dementia/Alzh ❑Cancer ❑Other: _____________________

❑ Emergency Contact's Information OR ❑ Power of Attorney's Information

Name: ________________________________ **Relationship**: ________________ **Home Phone**: _________________

Cell Phone: ____________________________ **Email**: ____

Address: _____________________________________ **City**: __________________ **State**: ______ **Zip**: ___________

Patient's Insurance Information

Primary Insurance Company: ____ **Phone**: ____________________

Address: ____________________________________ **City**: __________________ **State**: ______ **Zip**: ___________

Primary Insured Party: ________________________________ **Relationship to Patient**: ________________________

Policy #: __________________________ **Group**: _________________________ **Group Coverage?** ❑ Yes ❑ No

Secondary Insurance Company: ____ **Phone**: ___________________

Address: _____________________________________ **City**: ________________ **State**: ________ **Zip**: ___________

Secondary Insured Party: ________________________________ **Relationship to Patient**: _____________________

Policy #: __________________________ **Group**: _________________________ **Group Coverage?** ❑ Yes ❑ No

Office 469-642-3100
Fax 855-785-2415
contact@DiamondHouseCalls.com
DiamondHouseCalls.com