LifeCare Alliance · Patient Referral Form

1699 W. Mound St · Columbus, OH 43223
Phone: 614-278-3141 · Fax: 614-278-3143 · Email: referral@lifecarealliance.org

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Nourishing The Human Spirit.

- **Referring Agencies**: Please complete sections A, B and C of this form.
- **Physician's Offices:** Please complete sections D and E of this form.

A. Referring Agency

Today's Date:

Agency Representative Making Referral:

Phone Number: **Email Address:**

1. **As the Referring Agency representative, I have communicated the service basics and referral process for the identified LifeCare Alliance services checked on this form to the below patient.** ☐ Yes ☐ No
2. **The patient referenced on this form agrees to proceed with the assessment process for the identified service(s).** ☐ Yes ☐ No

If you answered no to either #1 or #2 above, provide background information so that we may proceed with initiating service:

B. PATIENT INFORMATION

Patient Name:	**DOB:**	**Phone Number:**
Street Address:	**City, State:**	**Zip:**

Emergency Contact:	**Emergency Contact Relationship:**	**Emergency Contact Phone:**
Primary Insurance:	**Member ID #:**	**Group #:**
Secondary Insurance:	**Member ID #:**	**Group #:**
Patient's Physician:	**Physician's Fax:**	**Physician's Phone:**

Veteran ☐ Yes ☐ No If yes, please include a copy of patient's DD214 with completed referral form, if possible.

Franklin County Senior Options Recipient ☐ Yes ☐ No If yes, provide case manager's name: _____
Services being received, if applicable:

PASSPORT/MyCare Ohio Recipient ☐ Yes ☐ No If yes, provide case manager's name: _____
Services being received, if applicable:

This person receives home-delivered meals already. ☐ Yes ☐ No **If yes, what is the meal provider?**

Client ID# _____ LifeCare Alliance RD's Name (if applicable)_____

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C. SERVICES BEING REQUESTED (check all that apply)

Diabetic or Nutritional Counseling

- ☐ **Medical Nutrition Therapy (MNT)**
- ☐ **Diabetes Self-Management Training (DSMT)**

Supportive In-Home Services

- ☐ **Home-Delivered Meals*+ –** Daily Hot
- ☐ **Home-Delivered Meals*+ –** Weekly frozen
- ☐ **Safety/Wellness Check Only (no meal needed)**
  - **Frequency:** ☐ **Daily** ☐ **Weekly** ☐ **Other _____**
  - **Verifying:** ☐ **Blood pressure** ☐**Blood sugar**
    ☐ **Weight** ☐ **Other _____**
  - **Report to referring agency when**
- ☐ **Meal Preparation**
- ☐ **Home Repair Assistance**

***Other Service* – please provide as much detail as possible, explaining service(s) requested:**

***Please pick only one.**

+Meal customers must be home to receive the delivery and must sign/initial delivery receipt.

D. PATIENT MEDICAL HISTORY

ICD DIAGNOSIS CODE(S):

Complete the below for Diabetic or Nutritional Counseling only

MOST RECENT A1C RESULTS:	DATE OF A1C TEST:	LABS: ☐ Labs Enclosed ☐ No Current Labs	MEDICATIONS: ☐ RX List Enclosed ☐ No RX List

E. REFERRING PHYSICIAN *(To be completed by physician's office)*

Practice Name:	Phone #:	Fax #:
Street Address:	City, State:	Zip:
PCP/Referring Physician Name *(please print):*	NPI #:	Medicare #:
PCP/Referring Physician Signature:		Date Signed:

Client ID# _____ LifeCare Alliance RD's Name (if applicable)_____