

# PharmaCare Health Specialists Intake/Referral Form

Date: \_\_\_\_\_

PATIENT	Patient's Name	SSN	DOB
	Address	Ht	Wt
	City, State & Zip	Home Phone	Work Phone
	Emergency Contact	Relationship	Phone

PHYSICIAN	Ordering Physician	Phone	Fax
	Address	City, State & Zip	
	Secondary Physician	Phone	Fax
	Address	City, State & Zip	

DIAGNOSIS / THERAPY	Diagnosis	Allergies
	Type of Line	Date Inserted
	Prescribed Therapy (Dose, Frequency, Route, Duration):	<input type="checkbox"/> Yes <input type="checkbox"/> No First Dose?
	Nursing Agency	Nurse on Case
		Phone

INSURANCE	Primary Insurance	Policy Number	Group Number
	Claims Address	Policy Holder	Phone
	Policy Information	<input type="checkbox"/> Yes <input type="checkbox"/> No Deductible Met?	<input type="checkbox"/> Yes <input type="checkbox"/> No In Network?
	Secondary Insurance	Policy Number	Group Number
	Claims Address	Policy Holder	Phone

**Comments:**