CareMate Wellness Solutions

Homecare Referral Form

Person Submitting Referral _____
(First and Last Name Please)

Facility_____ **Contact** _____

Phone_____ **Fax** _____

Patient_____ **M** ☐ **F** ☐ **DOB:** _____

Patient's Complete Address_____

_____ TX _____
(City) *(State)* *(Zip)*

Phone: _____ Last 4 of SSN: XXX-XX-_____

Medicaid #: _____

Insurance Co. _____ Ins Co. Phone _____

Policy # _____

Patient Primary Diagnosis _____

Secondary Diagnosis _____

Physician: _____**NPI#** _____

Phone: _____ **Fax** _____

Please indicate patient's last MD visit date:_____ or hospital discharge date:_____
(mm/dd/yy) *(mm/dd/yy)*

Requested Start Of Care date: _____

Physician's signature _____ Date: _____

Please fax or email this form and any additional documents to:

Fax:(682) 323-8692 | email: clientcare@carematewellnesssolutions.com

Thank you for trusting us to care for your patient!