BESTCARE PHARMACY **REFERRAL INTAKE FORM**

New Order ☐ Add-On ☐	Serving Branch	Patient I.D. #
Order received by	Date	Branch

Referral Source

Name/Agency	Contact	Phone #
Home Health	PT/OT	

Patient Demographics

Patient Name			Sex M F
Physical Address			Marital Status M S O
Mailing Address			DOB
City/State/Zip			SS #
Phone #	Alternate #	Residence: Home ☐ NH ☐ Other ☐	
Parent/Guardian		Relationship	
Height	Weight	Primary Language if other than English	
History of infectious disease	No ☐ Yes ☐	If yes list type	
Advanced Directive/DNR on file	No ☐ Yes ☐	If yes list type	

Emergency Contact (Someone NOT residing with patient)

Name	Relationship	POA: Yes ☐ No ☐
Address	Phone	

Physician Information

Prescribing Physician		Following Physician (if different)	
Name		Name	
Address		Address	
Phone:	Fax:	Phone:	Fax:
NPI #	Specialty	NPI #	Specialty

Insurance

Medicare ☐ HICN#	Medicaid ☐ ID #
Part B Effective Date	Title 19 Yes ☐ No ☐
Home Health Stays	Waiver ICF/MR (DDSD) Yes ☐ No ☐
Medicare HMO Yes ☐ No ☐	Waiver Advantage (LTCA) Yes ☐ No ☐
Primary Insurance (If not Medicare or Medicaid)	Secondary Insurance
Name	Name
ID #	ID #

Equipment Ordered/Previous Services

Diagnosis	Equipment Ordered
Directions	
List other DME patient has. Include supplier and delivery/pickup dates when possible:	
CPAP BiPAP CPM	Settings
Rx: LPM Via Hrs./Day O2 Sat. Test Date	Performed by: