IN-HOME PHYSICIANS
Total Healthcare Services

Phone:773-774-7300 **Referral Fax: 708-320-2034**

Referring Agency Information

Date:	**Agency Name:**	**Referral Source (If Different):**
Contact Name (Nurse, Case Worker):	☐ **Medical** ☐ **Podiatry** ☐ **Dietitian**	
Contact Phone:	**Fax:**	**Other Phone:**

Patient Information

Patient Name:		**Phone:**	
Address:		**Other Phone:**	
Address Line 2 (apartment complex name, number, door code if any)		**Email Address:**	
City:		**State:**	**Zip Code:**
SSN:	☐ **Male** ☐ **Female**	**DOB:**	**Marital Status:**
Caregiver/Contact:		**Phone:**	
PCP Name (if any) and Phone/Fax:		**PCP NPI:**	**Date last seen by PCP:**
Recent Hospitalizations:			
Is Patient Currently Living at a Facility? ☐ **Yes** ☐ **No**		**If yes, Name of Facility:**	

Insurance Information

Primary Ins:		**ID Number:**	
Plan Number:	**Group Number:**	**Date Effective:**	
Address:	**City:**	**State/Zip:**	
Secondary Ins:		**ID Number:**	
Plan Number:	**Group Number:**	**Date Effective:**	
Address:	**City:**	**State/Zip:**	
Date Medicare Verified: Internal Use Only	**Verified by:** Internal Use Only	**Medicare Primary** ☐ **Y** ☐ **N**	
Alternate Billing Addresss:			

Patient History

Allergies ☐ **Y** ☐ **N**	**List Allergies:**
Primary Medical Concerns	
Special Notes/Medication:	