accura health
a post-acute care management company

REFERRAL FORM

REVISED: 08/02/23

Date of Referral:					
Patient Information					
Patient Name:				Birth Date:	
Medicare ID:		SSN:		Gender: ☐M ☐F	
Patient's Address					
Type of Location:	☐ Home	☐ Hospital	☐ Nursing Home	☐ Res Care	☐ Other
Street Address:		City/ZIP:		Telephone:	
Contact Name for Facility if applicable:				Facility Contact's Phone:	
Is the Client aware of this referral? ☐ Yes ☐ No					
Insurance Provider					
Primary Insurance:		Member ID:			
Secondary Insurance:		Member ID:			
Secondary Contact					
Name & Phone of Patient's Secondary Contact		Name:		Contact's Telephone:	
Relationship to Patient:		Address:		City/Zip:	
Does Client have a Legal Guardian? ☐ Yes ☐ No ☐ Unk		☐ same as above		Name:	Telephone:
Does Client have a Medical POA? ☐ Yes ☐ No ☐ Unk		☐ same as above		Name:	Telephone:
Services Requested					
Transitional Care: ☐ Yes ☐ No		House-calls: ☐ Yes ☐ No		In-home: ☐SN ☐PT ☐HHA ☐OT ☐ST ☐MSW	
Referral Comment Information					
Referral Comments:					
Sign & Date					
Signature_____				Date: _____	

*****Email referrals to intake@accura.health or fax to 888-220-8663**

(Please include Face Sheet and the latest H&P)