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	☐Yes ☐No First Dose?

Prescribed Therapy (Dose, Frequency, Route, Duration): _____

Nursing Agency	Nurse on Case	Phone

INSURANCE

Primary Insurance	Policy Number	Group Number
Claims Address	Policy Holder	Phone
Policy Information	☐Yes ☐No Deductible Met?	☐Yes ☐No In Network?
Secondary Insurance	Policy Number	Group Number
Claims Address	Policy Holder	Phone

Comments: