CONTINUING PATIENT CARE FORM

REFERRAL ORIGINATED FROM:	TO:
	ROYALCARE, INC. 7125 Orchard Lake Road, Suite 303 *Tel: 248 626 9229* West Bloomfield, MI 48322 *Fax: 248 626 9230*
Reported By: Reported to:	Referral Date: Agency 1st visit date:

PATIENT INFORMATION

Last Name First Name MI	Sex: ☐Male ☐Female Marital Status: ☐S ☐M ☐W ☐D ☐ Sep. SS#: DOB:
Address of care: City or Town Phone#:	Patient Address:(if different): City or Town Phone#:

CONTACT PERSON / GUARDIAN

Contact Person: Relationship: Phone:	Guardian: Relationship: Phone:

HOSPITAL / PHARMACY / DME

Hospital Name: Hospitals admission date: Hospital discharge date:	Pharmacy: Phone#: DME Company: Phone#:

REPORTED BY PHYSICIAN

Primary Diagnosis: Secondary Dx: Surgery: Onset/Exacerbation dates:	Last M.D. visit date: Next visit date: Prognosis: ☐Good ☐Fair ☐Guarded ☐Poor Patient informed of Diagnosis: ☐Yes ☐No Family informed of Diagnosis: ☐Yes ☐No
Brief Medical History:	
Flu Shot received?: ☐No ☐Yes date:	Pneumonia Shot received?: ☐No ☐Yes date:

INSURANCE INFORMATION

Medicare No: Medicaid No: BCBS No: Group#:	Other insurance: Policy #: Name of Subscriber:

MEDICAL ORDERS AND PLAN OF TREATMENT

☐Skilled Nursing ☐Physical Therapy ☐Occupational Therapy ☐Speech Therapy ☐Home Health Aide ☐Social Worker ☐Dietician

Activity permitted: Diet: Med•: New/Changed Meds:	☐Evaluate and Treat ☐Assess and evaluate patient status ☐Teach disease process, meds ☐Wound Care ☐Lab Work: ☐Supplies/DME needed: Rehab Goal:

☐Other Orders:

PHYSICIAN INFORMATION

Physician Name: NPI# License#

Address:

Telephone#: Fax#:

I certify that the above patient is under my care, requires the above home health services, and is confined to his/her home. These professionals are to be provided on an intermittent basis and the established plan will be reviewed by me at least every 60 days. These services are related to the diagnosis stated above and conditions for which he/she received treatment while recently in hospital or office/clinic.

Physician Signature:	FOR OFFICE USE Person completing referral: ☐Referral Complete ☐ Incomplete ☐ Call back required Case Manager:

Thank you for your business. (To complete this referral, we may need to contact you or your office for additional information.)