



Preferred Gold -
 Concierge Care
 2357 60th Street
 Brooklyn, NY 11204
 Office: 212-308-8100 24/7
 Fax: 718-532-4117
 preferredgoldphc.com

REFERRAL FORM

Date: _____ **Referral Source:** _____
First Name: _____ **Last name:** _____
Date of Birth: _____ **Language:** _____ **Sex:** **Male** **Female**
Address: _____ **City:** _____ **State:** _____ **Zip:** _____
Home phone: _____ **Cell phone:** _____
Emergency Contact: _____ **Relationship:** _____
Phone Number: _____ **Email address:** _____

<p>Service days _____</p> <p>Service hours _____</p> <p>Type of Service (s): Escort <input type="checkbox"/> Companion <input type="checkbox"/> HHA/PCA <input type="checkbox"/> Skilled Nursing <input type="checkbox"/> Shift Nursing <input type="checkbox"/></p> <p>Rate _____</p> <p>Method of Payment: ACH <input type="checkbox"/> Credit Card <input type="checkbox"/> Long term Insurance <input type="checkbox"/> LTC Carrier and Other Information _____ _____ _____ _____</p>	<p style="text-align: center;">Patients care information:</p> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 80%;"></th> <th style="width: 10%; text-align: center;">YES</th> <th style="width: 10%; text-align: center;">NO</th> </tr> </thead> <tbody> <tr> <td><u>Lives alone:</u> _____</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td><u>Self-Directing:</u> _____</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td><u>Bedbound:</u> _____</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td><u>Hoyer Lift</u> _____</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td><u>Pet (s):</u> _____</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td><u>Smoker:</u> _____</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td><u>Self-Administer Medication:</u> _____</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td><u>Medication Handled by Family:</u> _____</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td><u>Dementia:</u> _____</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td><u>Allergies</u> _____</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </tbody> </table> <p>Height: _____ Weight: _____</p> <p>Assistive Device (s): WC <input type="checkbox"/> Walker <input type="checkbox"/> Cane <input type="checkbox"/> Crutches <input type="checkbox"/> Shower Chair <input type="checkbox"/></p> <p>Caregiver Sex: Male <input type="checkbox"/> Female <input type="checkbox"/></p> <p>Diagnosis: _____</p>		YES	NO	<u>Lives alone:</u> _____	<input type="checkbox"/>	<input type="checkbox"/>	<u>Self-Directing:</u> _____	<input type="checkbox"/>	<input type="checkbox"/>	<u>Bedbound:</u> _____	<input type="checkbox"/>	<input type="checkbox"/>	<u>Hoyer Lift</u> _____	<input type="checkbox"/>	<input type="checkbox"/>	<u>Pet (s):</u> _____	<input type="checkbox"/>	<input type="checkbox"/>	<u>Smoker:</u> _____	<input type="checkbox"/>	<input type="checkbox"/>	<u>Self-Administer Medication:</u> _____	<input type="checkbox"/>	<input type="checkbox"/>	<u>Medication Handled by Family:</u> _____	<input type="checkbox"/>	<input type="checkbox"/>	<u>Dementia:</u> _____	<input type="checkbox"/>	<input type="checkbox"/>	<u>Allergies</u> _____	<input type="checkbox"/>	<input type="checkbox"/>
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Comments

