Total Care 2 U
Care is our specialty. Our priority is you.

Referral Form
Fax: 877-926-5332
Phone: 877-868-2528
Intake@totalcare2u.com

☐ **Chronic Patient** ☐ **Transition Patient** **DC Date** ________ **Date**____________

Patient needing Primary Care services and has not been discharged from a healthcare facility within the last 48 hours

Patient must have been discharged from a healthcare facility within the last 24 hours

Home Health Name: ____________________ **Telephone:** _______________ **Fax:** ____________
Email Address:_________________________
(IF Different from HHA) Referral Name:____________ **Fax #:**______ **Phone #:**_________

PATIENT INFORMATION

Patient Name: ______________________________

DOB:____/____/____: SSN: ___-__-_____________Sex: ☐ M ☐ F

Phone: ______________ POA: ___________ POA #: ___________

Relationship to POA:__________________

Address: __________________________Building #___or Apartment #:___City:____State:___Zip: _____

Alternate Contact: ____________________ Relationship: _______________ Phone: _______________

INSURANCE INFORMATION

Medicare #: _____________________________

Secondary Insurance Carrier: ____

ID#: _________________ Group # (if applicable): __________________ Effective Date: _____________

PLEASE ATTACH MEDICAL RECORDS TO THIS REFERRAL

EMAIL COMPLETED REFERRAL TO: INTAKE@TOTALCARE2U.COM

OR

FAX COMPLETED FORM TO: 877-926-5332