BIDCO Housecalls Medicine Program Referral

Phone: 617-754-1082 Fax: 617-754-1055

Date/Time of Referral:	Practice/Program/Office of Referral
Referral Source Name: Person completing this form:	
Phone:	Email:
Active Community Nurse Care Manager case: ☐ Yes Name: ☐ No	
Submit with referral form: ☐ Last annual/comprehensive evaluation or admission H&P ☐ Last office visit note or discharge summary ☐ Medication list with allergies ☐ Last CBC, CMP, HbA1c, and other pertinent lab	

Patient Demographics

Name:	DOB: Gender:
Address: City:	State/Zip:
Fluent in English? Y/N If no, Primary Language: Interpreter Needed? Y/N	Phone:
Primary Insurance & Number	Secondary Insurance & Number
Primary Contact for Patient:	Home Number: Cell Number:

PCP Information

PCP Name:	Phone: Fax:
Reason for Referral:	Email EHR System

Referral has been reviewed and approved by the PCP ☐ Yes ☐ No
Has the patient been informed about the referral? ☐ Yes ☐ No

Past Medical History

☐ Diabetes ☐ COPD ☐ Heart Disease/CHF ☐ PVD ☐ Chronic Renal Failure ☐ Stroke/TIA
☐ Arthritis ☐ Neuromuscular Disease ☐ Dementia ☐ Depression
☐ Other: ____

Barriers to Care/High Risk Needs

☐ Hospital Admission Dates in last 12 months:
☐ ED Evaluations dates in last 12 months:
Add comments as necessary:

Geriatric Syndromes: ☐ Fall ☐ Urinary Incontinence ☐ Sleep Disturbance ☐ Frailty

Please check any of the following ADLs for which the patient requires assistance:
☐ Bathing ☐ Dressing ☐ Toileting ☐ Transfers ☐ Feeding ☐ other____________________

Health Care Proxy Name/Number: Is HCP Active? ☐ Yes ☐ No
Advance Directives/MOLST: ☐ Yes ☐ No <u>Please attach if Yes</u>

Referral Type

☐ Routine
☐ Expedited
☐ Post Discharge: ☐ Hospital ☐ SNF ____________________