SUBMIT BY FAX SUBMIT BY EMAIL

RESURGIA PATIENT REFERRAL FORM

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FAX COMPLETED FORM TO: (404) 445-5173 OR EMAIL TOINTAKE@RESURGIA.COM USING SECURE EMAIL.

Referrer Information

Referring Company/Name: Referral/Registration Date:

Contact Phone/Fax: Requested Visit Date:

In-Patient/SNF Discharge: ☐ Yes ☐ No Facility: Discharge Date:

Was patient notified of potential trip fees / co-pays: ☐ Yes ☐ No

How did you hear about Resurgia?

Patient Contact Information

First Name: Last Name: MI: DOB:

Address: Residence Type:

City: State: Zip: Marital Status:

Primary & Secondary Phone: Ethnicity: Gender: ☐ M ☐ F

Associated Email Address:

Emergency Contact Information

Last Name: First Name: Relationship:

Address: City:

State: Zip: Phone 1: Phone 2:

Patient Health Summary

Patient Risk Score [1=Low, 10=High]: Diabetes: ☐ Type I ☐ Type II ☐ NA

Pharmacy: Phone/Fax:

Is patient currently receiving any of the following (check all that apply):

☐ Ventilator ☐ Tracheostomy ☐ Oxygen ☐ Feeding Tube ☐ Pressure Ulcers

☐ Hospice ☐ Home Health ☐ Wound Care ☐ Personal Care ☐ Skilled Nursing ☐ Long Term Care ☐ Case Mgmt.

Providing Agency/Svc: Phone/Fax:

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Patient Insurance Information

	Primary	Secondary	Other
Carrier:			
Policy Type (HMO, PPO etc.):			
Group #:			
Patient ID # or Policy #:			