VIP 2U

Visiting In-Home Physicians To You

NEW PATIENT REFERRAL FORM

Phone: 312-728-4728
Fax: 312-728-4729
Email: intake.referrals@vip2upc.com

PATIENT NAME: *(Last)* _____ *(First)* _____ *(MI)*____

ADDRESS: _____ APT/BLDG #: _____

CITY: _____ STATE: _____ ZIP: _____

☐ House ☐ Apartment ☐ Domiciliary NAME OF FACILITY/APPT: _____

PATIENT PHONE: _____ IS THIS THE NUMBER TO CALL WHEN MAKING APPTS: ☐ *YES* ☐ *NO*

PATIENT EMAIL: _____

SSN: _____ DATE OF BIRTH: _____ GENDER: ☐ *Male* ☐ *Female*

MARITAL STATUS: ☐ *Single* ☐ *Married* ☐ *Widowed* ☐ *Divorced* NAME OF SPOUSE: _____

CONTACT IN THE EVENT OF AN EMERGENCY: _____

RELATIONSHIP TO PATIENT: _____ PHONE: _____

DOES THE PATIENT HAVE A POA/GUARDIAN: ☐ YES ☐ NO *(Skip This Section)* LEGAL STATUS: ☐ *POA* ☐ *GUARDIAN*

NAME: *(Last)* _____ *(First)* _____

ADDRESS: _____ APT/BLDG #: _____

CITY: _____ STATE: _____ ZIP: _____

RELATIONSHIP TO PATIENT: _____

POA/GUARDIAN PHONE: _____ NOTIFY BEFORE EACH VISIT? ☐ *YES* ☐ *NO*

PATIENT HEALTH ISSUE/REASON FOR REQUESTING HOUSE CALL: _____

SPECIAL VISIT INSTRUCTIONS: _____

IS PATIENT CURRENTLY BEING TREATED BY A PRIMARY PHYSICIAN? ☐ *YES* ☐ *NO*

NAME OF PCP: _____ PCP PHONE: _____

IS THE PATIENT CURRENTLY ON OR RECEIVING: ☐ *HOSPICE* ☐ *HOME CARE* ☐ *AIDE SERVICES* OTHER: _____

NAME OF AGENCY PROVIDING SERVICES: _____

HOW DID THE PATIENT HEAR ABOUT OUR SERVICES: ☐ *WORD OF MOUTH* ☐ *HHA* ☐ *FACILITY* ☐ *MARKETING* ☐ *OTHER*

REFERRING PARTY: _____ PHONE: _____

MEDICARE: _____ EFFECTIVE DATE: _____ HMO INVOLVEMENT: ☐ *YES* ☐ *NO*

PART B ELIGIBLE: ☐ *YES* ☐ *NO* OPEN MSP: ☐ *YES* ☐ *NO* VERIFICATION: ☐ *C-SNAP* ☐ *PHONE*

MEDICAID (If Applicable): _____ EFFECTIVE DATE: _____ HMO INVOLVEMENT: ☐ *YES* ☐ *NO*

OTHER INSURANCE (If Applicable): _____

POLICY NUMBER: _____ GROUP NUMBER: _____

TYPE OF POLICY: ☐ *HMO* ☐ *PPO* ☐ *TRADITIONAL* ☐ *PFFS* PHONE: _____

IN-OFFICE USE ONLY

WAS THE PATIENT CORRECTLY NOTIFIED OF POSSIBLE CO-PAYS/INSURANCE COVERAGE: ☐ YES ☐ NO

DATE OF REGISTRATION: _____ ASSIGNED VIP2U PHYSICIAN: _____

DATE OF FIRST VISIT: _____ REFERRAL COMPLETED BY: _____