CENTERS PLAN FOR HEALTHY LIVING

REFERRAL SUBMISSION FORM

Referral Instructions:
Best time to contact Patient – Check One
☐ Day ☐ Evening

Referred By:	**Referral Date:** **Phone:** **Fax:**
Email: :	

CLIENT REFERRED TO CPHL — **DOUBLE CLICK ON APPROPRIATE BOX**

Name: **Address:** **City:** **State:** **Zip:** **Phone:** **Current Location of Patient :**	**Sex** ☐ Male ☐ Female **Marital Status** ☐ Married ☐ Widowed ☐ Divorced ☐ Single ☐ Separated **Date of Birth:** **Age:** **Is Patient aware of referral:** ☐ Yes ☐ No
Client Lives Alone ☐ Yes ☐ No **Animals / Pets** ☐ Yes ☐ No	**Primary Language:** **English-Speaking:** ☐ Yes ☐ No

ADVOCATE / HOUSEHOLD MEMBERS / SIGNIFICANT OTHERS / EMERGENCY CONTACT

Name	Relationship	Phone

CLIENT'S SOCIAL SECURITY NUMBER:
Medicare #:
Medicaid #:

PRIMARY CARE PHYSICIAN:
Address:
Phone:
NPI: **License #:**

PATIENT DIAGNOSES:

AGENCIES CURRENTLY SERVICING PATIENT / CFEEC

Name of Agency: **Type:**	**CFEEC:** ☐ Yes ☐ No **MAXIMUS CALLED:** ☐ Yes ☐ No **If Yes, Date_____, Time_____**

Please ensure appropriate authorization was received to disclose the information to CPHL.