Ephraim McDowell
Patient Referral Form

Please Fax this Form To: 859-239-1766

Use this form for Doctor Office and Case Manager Referrals Only.

The referral is from: Doctor's Office ☐ Case Manager ☐

Patient Information:

First Name: ____

Middle Name: ____

Last Name: ____

Primary Phone Number: ____

Date of Birth (mm/dd/yy): ____

MRN: ____

Referral Information:

Social Worker Name: ____

Referring MD Name: ____

Are you a Hospital or Clinic?

Hospital ☐ Clinic ☐

Organization Name: ____

Discharge Information:

Possible Discharge Date: ____

Is Patient Homebound?

Yes ☐ No ☐

Max Patient: ____

Discharge Drug Name/ Dose/Frequency: ____

Is Patient current with HHA?

Yes ☐ No ☐