CHARM MEDICAL SUPPLY

FAX: 781-829-9836

REFERRAL FORM

NEW PATIENT REFERRAL

PHONE: 877-94CHARM

Referral being requested by:
Name:
Relationship:
Phone#:
How did you hear about Charm?
PATIENT INFORMATION: **PLEASE COMPLETE *ALL* LINES**
Organization:
Patient Name:
Street:
Apt/Floor:
City:
Zip Code:
Phone Number for Monthly Order Confirmation:
Phone (MAIN):
Phone (ALT):
FAX :
E-mail:
D.O.B.:
Weight:
Height:
Diagnoses:
Patient/Caregiver Primary Language:
Does patient, or any other person in the residence, have a communicable disease?
If "yes," please describe:
INSURANCE INFORMATION:
Primary:
Policy ID#:
Secondary:
Policy ID#:
Mass Health Card ID#:
Social Security #:
PHYSICIAN INFORMATION:
Primary MD:
Practice Name:
Street:
Town, State & Zip:
Telephone:
FAX:

For Group Homes, Assisted Living, etc: **HOUSE MANAGER CONTACT INFORMATION:**
Name:
Telephone:
Title:
Is there a VNA in the home?:
Name:
Phone #:
PRIMARY CONTACT/ LEGAL GUARDIAN:
Name:
Relationship:
Address:
Telephone:
**** SEND NEW PATIENT INFORMATION PACKET TO:***
☐FAX : ***☐ EMAIL:***
Is patient currently with another supplier?
Name of company:
Supplies patient is receiving:
SUPPLY REQUEST:
In space below, please list the supplies needed monthly. ***Be specific as to amounts needed per month, as well as sizes, styles, flavors, ounces, etc.***
THIS FORM COMPLETED BY:
RELATIONSHIP: