CHARM MEDICAL SUPPLY

NEW PATIENT REFERRAL FORM

PHONE: 877-94-CHARM

FAX: 781-829-9836

REFERRAL BEING REQUESTED BY:

Name:	
Relationship:	
Phone #:	
How did you hear about CHARM?	

PATIENT INFORMATION:
Please complete all lines

Organization Name:	
Patient Name:	
Street:	
Apt/Floor:	
City:	
Zip Code:	
DOB:	

Phone Number for Monthly Order Confirmation

Phone (Main):	
Phone (ALT):	
FAX:	
E-Mail:	

Weight:	
Height:	
Diagnoses:	
Primary Language:	
Does any person in the residence have a communicable disease?	
If yes:	

INSURANCE INFORMATION

Primary:	
Secondary:	
Mass Health Card ID#:	

PHYSICIAN INFORMATION

Primary MD:	
Practice Name:	
Street:	
City:	
Phone:	
Fax:	

For Group Homes, Assisted Living, etc:
HOUSE MANAGER CONTACT INFORMATION

Name:	
Title:	
Phone #:	
Is there a VNA in the home?	
Name:	
Phone #:	

PRIMARY CONTACT / LEGAL GUARDIAN

Name:	
Relationship:	
Address:	
Phone #:	

SEND NEW PATIENT INFORMATION PACKET TO:

FAX:	
E-Mail:	
Is patient currently with another supplier?	

SUPPLY REQUEST:
Specific as to amounts needed per month, as well as sizes, styles, flavors, ounces etc.

GLUCOMETER / DIABETIC SUPPLIES REQUEST:

Has the patient received prior education about proper diabetic supply disposal methods?	
HAS THE INSURED BEEN NOTIFIED THAT SUPPLIES ARE BEING REQUESTED ON THEIR BEHALF AND TO EXPECT A CALL FROM CHARM?	

Date:	
Completed by?	
Relationship to patient:	

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