Mason-Dixon Mobile Medicine
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Time for a home visit?

New Patient Referral Form

Patient name ________________________ DOB ________________________
Address ________________________ phone ________________________
____

Services Requested

___ home-based primary care
___ home-based palliative care
___ transitional care management
___ other (specify): _______________

Checklist

Please include the following items (* = preferred)

* Face sheet / demographics
* Health Insurance: **[NOTE: Medicare Part B and Aetna plans ONLY]**
  - Payer name & contact information
  - Group and member numbers

Hospital / SNF Notes
  - * admission H&P
  - * discharge summary
  - * meds list
  - imaging reports
  - most recent lab values

Advance directives
  - medical POA
  - POLST/MOLST

Your contact info

Name ___________________ phone ___________________

Organization ___________________ email ___________________