



Mason-Dixon Mobile Medicine

www.masondixonmed.com
☎240.397.6723 📠833-992-0865



House calls are BACK!!!

New Patient Referral Form

Patient name _____
Address _____

DOB _____
phone _____

Services Requested

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

Checklist

Please include the following items (* = required; + = preferred)

- * Face sheet / demographics
- * Health Insurance: [**NOTE: Medicare Part B / Hopkins MA ONLY**]
 - Medicare / MA number: _____
 - Secondary payer name & contact information
 - Secondary group and member numbers
 - Contact info for responsible party
 - Name _____
 - Phone _____
- 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 _____



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