

FAX

To: Upstate HomeCare **Fax#:** 315-802-5780

From: (Name) (Location) (Phone#)

RE: New Referral **Pages:**

Patient Name: **Date of Birth:**

Diagnosis: **Medicaid CIN#:** **Medicaid PA#:**

Allergies: **Height:** **Weight:**

Access:

Referral Checklist - Please Attach the Following

Demographics	H&P	Progress/Nutritional Notes	Labs	Med Profile
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Medication Ordered

Formula:	Sig: ___ cans via ___ daily	Quantity: ___ can/mth	Refills: 5
Formula:	Sig:	Quantity:	Refills: 5
Formula:	Sig:	Quantity:	Refills: 5
Formula:	Sig:	Quantity:	Refills: 5

Modality:

Enteral Pump (lifetime)	Quantity 1
Pump Supply Kit	Refill x5
Bolus Supply Kit	Refill x5
Gravity Supply Kit	Refill x5

Access:

MK Button	_____ Fr	_____ cm	Refill x1
AMT Button	_____ Fr	_____ cm	Refill x1
NG Tube	_____ Fr	_____ inches	Refill x5
G Tube	_____ Fr		Refill x5

Prescriber Signature: _____ **Date:** _____

Print Name: _____ **NPI#:** _____

By signing this form, you, as the following physician are authorizing Upstate HomeCare to transcribe the above order into verbal orders.

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