SWING BED REFERRAL RECORD

PATIENT INFORMATION

Patient Name								Referral Date	___ /___ /___
DOB	___ /___ /___	Age		Race		Sex	❒ M ❒ F	Marital Status	❒ M ❒ S ❒ W
Home Phone								Cell	
Address									

Referring Hospital		Attending/Referring MD	

Admission Date		Discharge Date	

Primary Care Giver		Relationship	
Home Phone		Cell Phone	

Primary Diagnosis		Secondary Diagnosis	

Care Coordinator		Coordination Phone	
Skill(s) Requested	❒ Skilled Nursing	❒ Occupational Therapy (requires add'l skill primary)	
	❒ Wound Care, IV Therapy	❒ Speech-Language Pathology (requires add'l skill primary)	
	❒ Physical Therapy		

Requested Treatments	

INSURANCE INFORMATION

Primary		Policy #	
Secondary		Policy #	
Policy Holder		Group #	

DOCUMENTATION REQUIRED

Please include with this completed form:

- ☑ Patient Demographics
- ☑ History & Physical
- ☑ Medication List
- ☑ Therapy Notes
- ☑ Lab/Radiology/Procedure Results
- ☑ MD Progress Notes
- ☑ Nursing Notes
- ☑ Any additional information pertinent to patient's care

Please Fax Referral Packet to: 828-586-7783 Attention: Tammy Dills

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