HOME & COMMUNITY SERVICES
ALABAMA PUBLIC HEALTH

Alabama Department of Public Health

Phone:_____ **Fax:** _____

Physician's Referral for Services

Physician Information

Referring Physician:	Date of Referral:
Office Contact Person:	
Phone:	Expected Date to Begin Services:
Fax:	

Patient Demographics

Patient Name:		Home Phone:
Address:		Cell Phone:
		Work Phone:
DOB:	SSN:	Primary Language:
Family/Emergency Contact:		
Phone:	Relationship:	Power of Attorney: Y / N

Payor Source Information

Medicare or HMO#:
Medicaid #:

Medical Information **(IF MORE SPACE NEEDED, PLEASE SEND SEPARATE HISTORY & PHYSICAL)**

Primary Diagnosis:	Medications & Frequencies:
Other Diagnoses:	
Date(s) Last Hospitalization:	Allergies:
Additional Information:	

Services Requested

Discipline	Reason	Frequency	Duration
___ Skilled Nurse			
___ Physical Therapy			
___ Occupational Therapy			
___ Speech Therapy			
___ Medical Social Services			
___ Home Health Aide			
Special Instructions / Additional Information:			

Physician Signature: _____ **Date:** _____

Please Note: This referral form does not guarantee admission to the Alabama Department of Public Health services. Upon receipt of referral, our office will review information and contact you to further coordinate services. Our business hours are Monday-Friday 8:00am-5:00pm except state holidays. Thank you for your referral.