

# CHARTWELL QUICK REFERRAL

**Please call Chartwell prior to faxing this form**

Referral Line: (800) 730-8555 and/or (608) 831-8555 (24 hrs/day)

Referral Fax: (608) 831-9747

Person supplying referral info \_\_\_\_\_ Date \_\_\_\_\_

Pager# \_\_\_\_\_ Telephone# \_\_\_\_\_ Time \_\_\_\_\_

Hospital/Clinic \_\_\_\_\_ Rm# \_\_\_\_\_ Phone \_\_\_\_\_

Admit Date \_\_\_\_\_ **Discharge Date** \_\_\_\_\_ **SOC Date** \_\_\_\_\_ CMW Team \_\_\_\_\_

**Patient Information:**

**Name (Last, First, MI)** \_\_\_\_\_ MR# \_\_\_\_\_

Address \_\_\_\_\_ Sex: M / F

Phone \_\_\_\_\_ Social Security # \_\_\_\_\_ **DOB** \_\_\_\_\_

Emergency Contact / # \_\_\_\_\_ Relationship \_\_\_\_\_

**Allergies** \_\_\_\_\_ Ht. \_\_\_\_\_ Wt. \_\_\_\_\_

**Primary Dx** \_\_\_\_\_ Therapy Dx \_\_\_\_\_

**Anticipated Orders** \_\_\_\_\_ Received 1<sup>st</sup> dose: Y / N

When and where are labs being drawn? \_\_\_\_\_

**ACCESS:**(Circle) IM SubQ Peripheral HICKMAN® Port GROSHONG® PICC Size: \_\_\_\_/Sutured Y/N

Insertion date \_\_\_\_\_ Number of Lumens \_\_\_\_\_ Needleless System: \_\_\_\_\_

**Prescr/Attd Physician** \_\_\_\_\_ Phone \_\_\_\_\_

Following Physician \_\_\_\_\_ Phone \_\_\_\_\_

Nursing Agency (if applicable) \_\_\_\_\_ Contact Name \_\_\_\_\_

Agency's Phone# \_\_\_\_\_ Fax# \_\_\_\_\_ Patient aware of referral: Y / N

**Payor** \_\_\_\_\_ Phone# \_\_\_\_\_

Insured's Name \_\_\_\_\_ DOB \_\_\_\_\_ Gender \_\_\_\_\_

Policy# \_\_\_\_\_ Group# \_\_\_\_\_

**Payor** \_\_\_\_\_ Phone# \_\_\_\_\_

Insured's Name \_\_\_\_\_ DOB \_\_\_\_\_ Gender \_\_\_\_\_

Policy# \_\_\_\_\_ Group# \_\_\_\_\_

**\*\*\*REQUESTED FAX COPY OF\*\*\***

H&P  Current Labs  Line Insertion Progress Note  Current Medication List

Signed lab & medication orders, including anticipated duration of therapy

**Other Comments:** \_\_\_\_\_

Chartwell Signature: \_\_\_\_\_ Date: \_\_\_\_\_