

CHRISTUS HomeCare Referral Intake Form

SERVICES		
Skilled Home Care	Hospice	Private Duty Services
Community Care – PHC/CBA	Pediatrics	Pharmacy
PATIENT INFORMATION		
Name: _____	SSN: _____	
(Last)	(First)	(MI)
Address: _____		
City: _____	State: _____	Zip: _____
Phone #: _____	D.O.B. _____	Gender: _____
Emergency Contact: _____		Phone #: _____
DIAGNOSIS		
_____ _____ _____		
REFERRAL SOURCE		
Referral Source: _____		Phone #: _____
Referral Source's Name: _____		Pay Source: _____
INSURANCE		
Does Patient Have Insurance?	Yes	No
Carrier Name: _____	ID #: _____	
PATIENT CARE NEEDS		
_____ _____ _____		
ORDERS		
_____ _____ _____		
PHYSICIAN INFORMATION		
Name: _____		Phone #: _____
Address: _____		
City: _____	State: _____	Zip: _____
ADDITIONAL COMMENTS		
_____ _____ _____		

Please fill out each area and Fax to the appropriate Intake Office:

TEXAS

San Antonio, TX: 210-581-5296
Houston, TX: 713-520-6054
Nassau Bay, TX: 281-523-2550
Corpus Christi, TX: 361-994-3698

LOUISIANA

Lake Charles, LA: 337-480-3050
Jennings, LA: 337-824-4999
Shreveport, LA: 318-681-6764