DORAL

Health & Wellness

TELEHEALTH DEPARTMENT

REFERRAL FORM

PATIENT INFORMATION

Last Name First Name	Sex ☐ Male ☐ Female	Telephone
Address City	State	Zip Code
Social Security	Lives With ☐ Family ☐ Alone ☐ Caregiver	Date of Birth	Primary Language Spoken
Family Contact/Relationship	Telephone:	Cell:

REFERRAL SOURCE

Name:

Address	City	State	Zip Code

Telephone: ( )	Fax: ( )	Email:

INSURANCE

Medicare:

Medicaid:

Other:

TYPE OF MD ORDER NEEDED

1) **M11Q:** ☐ YES ☐ NO
2) **DOH:** ☐ YES ☐ NO
3) **485:** ☐ YES ☐ NO
4) **F2F:** ☐ YES ☐ NO
5) **CFEC:** ☐ YES ☐ NO

COMMENTS

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Would you want DORAL to be Primary Care Physician ? ☐ YES ☐ NO

DIAGNOSIS

1. ______________________ 3. ______________________
2. ______________________ 4. ______________________

MEDICATIONS/DOSE/FREQUENCY/ROUTE

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PHARMACY NAME:______________________________

PHARMACY TELEPHONE #: ______________________________

TEL: 718-971-1956 • FAX: 718-971-1957
www.DoralHW.org