pentec health

Large Enough to Serve *Small Enough to Care*

4 Creek Parkway Suite A · Boothwyn, PA 19061
Toll Free: (800) 223 4376 Fax: (800) 355 1029

REFERRAL FORM OPTION #1

Date of Referral ___/___/___

Referral Type: ❒ **IDPN** ❒ **IPN**

Malnutrition Type:
❒ Protein
❒ Calorie
❒ Protein / Calorie

Formula Choice:
❒ **Proplete**
❒ **Proplete Plus Standard**
❒ **Proplete Plus CHO Control**
❒ **Proplete IPN**

IDPN Only Dialysis Regimen (Check one): ❒ M/W/F ❒ T/Th/S **Time:** _____ am / _____ pm

Length of Treatment Time ❒ **2.75 to 3 Hours** ❒ **3.25 to 3.50 hours** ❒ **3.75 to 4 hours**

IPN Only (Check two): ❒ Baxter ❒ Fresenius ❒ CAPD ❒ CCPD

Contact Person

(Name/Title): ____________________

Unit Phone #: ____________________ Unit Fax #: ____________________

Contact E-mail: ____________________ Contact Mobile #: ____________________

Unit Address: ____________________
Street City State Zip

Physician Name: ____________________ DEA# ____________ NPI# ____________

Physician Address: ____________________

Physician Office Phone: ____________________ Physician Fax: ____________________

Patient Information

❒ Male ❒ Female ❒ Home ❒ Nursing Home Admit Date: ____________

Name: ____________________
First M.I. Last

Address: ____________________
Street Apt City State Zip

DOB: _____ / _____ / _____ SS# _______ - _______ - _______ Phone # ____________

Clinical Information

Height:_______Cm/In Weight:_______Kg/Lbs IBW: _______

Weight Change: _______gain/loss x _______mos.

Alb: _______ Date: _______ Alb: _______ Date: _______ Alb: _______ Date: _______

Kt/V: _______ Creatinine: _______ nPCR:_______

Allergies: ____________________

Date of First Dialysis: ____________________

Supplements Attempted: ____________________ **Length of Time:** ____________

Diagnosis: ❒ Diabetes ❒ Hypertension ❒ Severe Vascular Disease ❒ Severe Anorexia ❒ Severe Vomiting
❒ Gastroparesis ❒ AIDS ❒ Severe Nausea ❒ Severe Diarrhea ❒ Other: ____________

Insurance Information

Please List **ALL** insurance Information

Commercial: Plan Name: ____________________ Phone # ____________________
ID # ____________________ Group # ____________________
(Include any Letters)
Policyholder / Subscriber: ____________________ Employer: ____________________

Medicare: ID# ____________________ Letter: ____________________

Medicare Part D: Plan Name: ____________________ ID#: ____________________
Group#: ____________________ Phone#: ____________________

Medicaid: State: ____________________ ID# ____________________

Fax To: 800.355.1029 or 610.494.6148

_____ Pt Referral Form _____ Labs (3 mos) _____ Copy of Insurance Cards (Front and Back)

2/17/10 V1