BETTER FAMILIES, INC.
TEL: (646) 747-0181• FAX: (646) 747-0183
info@betterfamilies.com

REFERRAL FORM

Referral Date:_____ Referral Name:_____

Patient Information

First Name:_____ Last Name:_____
Address:_____
Cell Phone:_____ Home Phone:_____
DOB:_____
Sex: ☐M ☐F Marital Status:_____
Primary Language Spoken:_____Social Security #:_____
Lives with: Alone___ Family___ Friends ___ Other_____
Other Information:_____

Service Requested

☐ CDPAP

Caregiver #1 Name:_____
Phone:_____
Caregiver #2 Name:_____
Phone:_____

Insurance Information

Medicaid #:_____ Medicare #:_____
Other Insurance/HMO:_____
HHA/PCA Hours:_____ Current CHHA (Vendor):_____

Physician Information

MD Name:_____ MD Phone:_____
MD Address:_____ MD Fax:_____

Emergency Contact

First Name:_____ Last Name:_____
Relationship to Patient:_____ Phone:_____