REFERRAL QUESTIONNAIRE

PLEASE EMAIL OR FAX THIS FORM AND THE REQUESTED RECORDS TO: joanna.frisby@hillcrestrdc.com or Fax: 218-319-8474

Referral made by: (Name and preferred method of contact- Phone/Email)	
Potential Resident Name:	
Date of Birth:	
Diagnosis:	
Primary Care Physician: Any other Prescribers, please list -Name and Clinic	
Payor Source for Rent: (Private/ Housing Support- GRH): **Payor Source for Services: (Private/Waiver ex: CADI, EW)** Does this person have a rep payee in place and who?	
Senior Link of MN given: Verification Code Not Required- give them phone number 1(888)333-2433	
Insurance Information: (Primary/Secondary)	
County Worker(s): Case Manager, Financial Worker (Names & Contact Information)	
Where are they coming from:	
Expected Discharge/Admission time frame:	
Do they have a commitment or Jarvis? If yes, include copy	
Do they have a guardian or POA? If yes, include copy	

Which facility would be appropriate?	
Tour scheduled:	
***Most recent H&P, DA (if applicable) and Physician signed medication list and diagnosis list required for review prior to scheduling admission:**	
***A minimum of 14 day supply of medications must be brought with the resident or current/new Rx's must be sent to the pharmacy and delivered in time for the admission.**	