pinnacle HEALTH & REHAB | CANTON MAINE

Pinnacle Referral Form

Name:____ DOB: ___/___/___

Medicaid #: _______________________________ S.S.#: _______________________

Medicare #: ____________________ A: _________ B: ___________ (effective date)

Marital Status: __________________ Advance Directive: _____________________

Referral Source: ____

Anticipated Level of Care: __________ Has a MED (state) been completed Y N

Primary Care Doctor: ____

Address: ____

Phone: ___________________________ Fax: _____________________________

Most Recent Hospitalization: ____

Primary Diagnosis: ____

Weight: __________ lbs. Height: __________

Guardian: Yes ____ No ____ POA: Yes ____ No ____

Responsible Party Name: ____

Address: ____

Phone: _______________________ Email Address: _______________________

Other Contacts: ____

____

____

Allergies: ____

Long-Term Plan: ____

Please fax or Email this form to Tanya Smith, LSW at (207) 597-2580 or tsmith@pinnaclecanton.com