

Referral Form

Daniel Drake Center for Post-Acute Care

Please complete form and fax it with face sheet to 513-418-2599.

Patient Name: _____ Room Number: _____

Unit Phone Number: _____ Date of Admission: _____

Current Diagnosis: _____

Referring Physician: _____

Requested Evaluation Date: _____

Anticipated Discharge Date: _____

- Referring patient to: (Please Check One)
- LTAC/MEDICALLY COMPLEX - Main Campus
 - LTAC/MEDICALLY COMPLEX - The Christ Hospital
 - SHORT-TERM SNF < 30 DAY STAY

Comments: _____

Referring Facility: _____

Referring Social Worker: _____

Contact Number (cell or pager #): _____

Please call 513-418-4365 to confirm receipt of referral or for any questions.

The information contained in this facsimile transmission is confidential and intended only for the use of the individual or entity named above. It may contain confidential patient health information protected by state law and federal HIPAA regulations. If the reader of this message is not the intended recipient, you are hereby notified that you may not review, use, disclose, copy or distribute to anyone the information in this facsimile. Use or disclosure is prohibited and/or unlawful and may be considered a tortuous interference in our confidential business relationships. If you have received this communication in error, please immediately notify the sender at the contact number above and return the original message to us at the address above via U.S. Postal Service. We will reimburse you for all out-of-pocket costs so incurred. Thank you.

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