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.

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