Referral to Drake Center

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 Circle)

LTAC/MEDICALLY COMPLEX	SHORT-TERM SNF < 30 DAY STAY
LONG-TERM SNF > 30 DAY STAY	REHABILITATION
VENTILATOR UNIT	WOUND CARE / WOUND VAC

Comments: _____

_____

_____

_____

Referring social worker: _____

Contact Number (cell or pager #): _____

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

Rev 05/07