

## **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.**

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