

**POSSIBLE ADMISSION/REFERRAL FORM**

Client's Name: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ County: \_\_\_\_\_ Race/Sex: \_\_\_\_\_

CID #: \_\_\_\_\_ SS#: \_\_\_\_\_ Medicare/Medicaid#: \_\_\_\_\_

Hold Order? (Circle One)    Yes    No    Legal Status/Expiration Date: \_\_\_\_\_

Court Dates (if any): \_\_\_\_\_

Referring Physician/Staff/Agency/Phone #: \_\_\_\_\_

Client's Representative(s) (Include telephone numbers): \_\_\_\_\_

\_\_\_\_\_ Next of

Kin (include telephone number): \_\_\_\_\_

\_\_\_\_\_ Reason for  
Referral: \_\_\_\_\_

Primary/Attending Physician: \_\_\_\_\_

Allergies: \_\_\_\_\_

Advance Directives: \_\_\_\_\_

Current Medication and Dosage: \_\_\_\_\_

Medication(s) Given within Last 48 hours: \_\_\_\_\_

Current Physical Status: \_\_\_\_\_

Other Information: \_\_\_\_\_

Admitting Staff: \_\_\_\_\_ (Admitting Staff should initial information they collect)

Physician: \_\_\_\_\_ (Physician should initial information they collect)

**Client Approved for Evaluation: Yes    No**  
(Physician to Circle One)

Stamp Plate