CHARM MEDICAL SUPPLY

NEW PATIENT REFERRAL FORM

PHONE: 877-94-CHARM

FAX: 781-829-9836

CT & RI Fax: 888-977-1944

REFERRAL BEING REQUESTED BY:	
Name:	
Relationship:	
Phone #:	
How did you hear about CHARM?	

PATIENT INFORMATION: Please complete all lines	
Organization Name:	
Patient Name:	
Street:	
Apt/Floor:	
City:	
Zip Code:	
DOB:	

Phone Number for Monthly Order Confirmation	
Phone (Main):	
Phone (ALT):	
FAX:	
E-Mail:	
Height:	
Weight:	
Diagnoses:	
Primary Language:	
Does any person in the residence have a communicable disease?	
If yes:	

INSURANCE INFORMATION	
Primary:	
Secondary:	
Mass Health Card ID#:	

PHYSICIAN INFORMATION	
Primary MD:	
Practice Name:	
Street:	
City:	
Phone:	
Fax:	

For Group Homes, Assisted Living, etc: HOUSE MANAGER CONTACT INFORMATION	
Name:	
Title:	
Phone #:	
Is there a VNA in the home?	
Name:	
Phone #:	

PRIMARY CONTACT / LEGAL GUARDIAN	
Name:	
Relationship:	
Address:	
Phone #:	
Primary Language:	

SEND NEW PATIENT INFORMATION PACKET TO:	
MAIL & EMAIL	
FAX:	
E-Mail:	
Is patient currently with another supplier?	

SUPPLY REQUEST: Specific as to amounts needed per month, as well as sizes, styles, flavors, ounces etc.

GLUCOMETER / DIABETIC SUPPLIES REQUEST:	
Has the patient received prior education about proper diabetic supply disposal methods?	

Date:	
Completed by?	
Relationship to patient:	

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