EvoHome Medical GROUP

Office: (888) 491.6729 Fax: (888) 491.6759 400 N May St., Ste 201, Chicago, IL, 60642 info@evohomemedicalgroup.com

PRIMARY CARE PATIENT REFERRAL FORM

Purpose: This form collects essential information about the patient and their primary care needs to facilitate coordination between the referring provider and the primary care team, ensuring comprehensive, patient-centered care.

Referring Provider Information:

Name of Provider: _____

Provider Address: _____

Phone: _____ Fax: _____ Email: _____

Provider Contact:

Name: _____

Phone: _____ Fax: _____ Email: _____

Patient Information:

Patient Name: _____ Date of Birth: _____

Address: _____

Phone Number: _____ Emergency Contact: _____

Insurance Information:

Insurance Provider: _____

Policy Number: _____ Group Number: _____

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Reason for Referral:

☐ Establish Primary Care ☐ Annual Wellness Exam

☐ Chronic Disease Management (specify: _____)

☐ Preventive Screening (specify: _____)

☐ Follow-Up After Hospitalization ☐ Medication Management

☐ Other: _____

Current Medical Information:

Primary Diagnosis/Concerns: _____

Current Medications: _____

Relevant Medical History: _____

Additional Notes for Primary Care Team:

_____

_____

_____

_____

Referring Provider Signature: _____ Date: _____