Referral Fax Number:
336.532.0516

Referral Center Phone Number
336.621.7575

Number of Pages (including cover):______

GUIDE REFERRAL FAX FORM

Please fax this form, along with the demographic sheet and Problem List.

Name of Person completing this referral: ____________________

Referral Contact Number: ____________________

Patient Name: ____________________

Date of Birth: ______/______/______

Medicare #: ____________________

Referral for:

☐ GUIDE-Guiding an Improved Dementia Experience
☐ Companion Care-(GUIDE & Home Health)

Confirm the patient is NOT in the following:

- Living in a long-term skilled nursing facility
- Enrolled in a Medicare Advantage Plan, including Special Needs Plans
- Enrolled in Hospice or a PACE program

Community Provider Name (if different from referring name)

____

____________________	____________________	__________
Referring Provider Name (Print)	Provider Signature (Required)	Date

July 2024