

Essential Care Services, LLC.
600 N. Main Street, Suite A
Greer, SC 29650
Phone: (864) 655-7600
Fax: (864) 655-7602



New Referral Request Form

Date of Referral: _____

Name of Person making Referral: _____

Contact Person: (if different) _____ Phone: _____

Relationship to Client: _____

Potential Client's Name: _____ Phone: _____

() Male () Female DOB: _____ Address: _____

Race: _____ Medicare #: _____ Medicaid #: _____

Social Security #: _____

Name/ Type of Facility: _____

Reason for Referral:

Primary Physician: _____ Phone: _____

Physician Address: _____

Request of Start Date of Service: _____ Shift/Hours: _____

Name & Title of Employee taking Referral: _____

Rate Quoted: _____

OFFICE USE ONLY

Action Taken:

Entered in Referral System: () YES () NO

Date Entered: _____ Employee Making Report/Title: _____