



SWIRCA & More Referral Intake Form
Please fax to: 812-464-7811

Name: _____ Date/Time: _____
First M.I. Last

Address: _____ County: _____
Street Apt # City State Zip

Social Security #: _____ D.O.B.: _____ Age: _____ Male/Female (Circle One)

Veteran: Y/N (Circle One) Marital Status: M W D S Other _____

Does Referral have: POA, Guardian, Emergency Contact or Alternate Contact? (Circle One)
If Yes, Please list their Name, Relationship, Telephone # and whether or not Case Manager should
contact them when scheduling appointment. _____

Doctor: _____ Telephone #: _____

Diagnosis/Problems: _____

On Medicaid? Y/N (Circle One) If Yes Medicaid #: _____

Medicare # & Effective Date: _____

ICF Days: _____ SNF Days: _____ Admit Date: _____

Would In-Home Services be Safe & Feasible? Y/N (Circle One) Comments: _____

Additional Information/Remarks: _____

Nursing Facility: _____ Referral Source: _____

Telephone #: _____ D/C Date: _____