St. Bridget Care Solutions, LLC
Maryland-Licensed Residential Service Agency
Skilled Nursing Services & Home Infusion Therapy Support
Harford County | Cecil County | Northern Baltimore County, Maryland
stbridgetcare.com | Phone: 410-205-9887 | Fax: 410-841-6030 | Secure Email: SBCS@stbridgetcare.com

PHYSICIAN / PROVIDER REFERRAL FORM

Skilled Nursing Services and Home Infusion Therapy Support

Use this form to refer a patient for RN skilled nursing services, infusion therapy nursing support, chronic disease management, medication administration, wound care, post-discharge follow-up, and related home-based nursing needs. This form supports referral intake and does not replace payer-specific prior authorization, pharmacy orders, or plan-of-care requirements when applicable.

1. REFERRAL SOURCE / ORDERING PROVIDER

Referral Date			**Requested SOC Date**		
Urgency	☐ Routine ☐ 24-48 hrs ☐ Same-day review		**Referring Facility Type**	☐ Hospital ☐ PCP ☐ ALF ☐ SNF ☐ Infusion Pharmacy ☐ Other	
Ordering Provider			**NPI**		
Practice / Facility			**Contact Person**		
Phone		**Fax**		**Email**	

2. PATIENT INFORMATION

Patient Name		**DOB**	
Address		**City/State/ZIP**	
County		**Phone**	
Sex		**MRN**	
Emergency Contact		**Relationship**	
Emergency Phone		**Preferred Language**	
Insurance	☐ Private Pay ☐ Commercial ☐ Medicaid/MCO ☐ Other	**Policy / Auth #**	
Scheduling Contact	☐ Patient ☐ Family/Caregiver ☐ Facility	**Best Contact #**	

3. CLINICAL SUMMARY AND MEDICAL NECESSITY

Primary Diagnosis / ICD-10	
Secondary Diagnoses / Comorbidities	
Reason Skilled RN Is Needed	
Recent Hospital / ED / SNF Stay	
Pertinent Clinical Notes / Precautions	

4. SERVICES REQUESTED

☐ Skilled Nursing Assessment / Start of Care	☐ Chronic Disease Management / Education	☐ Medication Reconciliation / Teaching
☐ Medication Administration / Injection Support	☐ Wound Care / Dressing Changes	☐ Post-Hospital Discharge Follow-Up
☐ Infusion Therapy Nursing Support	☐ PICC / Midline / Port Care	☐ Lab Draws / Specimen Collection
☐ Catheter Care / Ostomy Support	☐ Fall Risk / Safety Assessment	☐ Other: _____

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5. SKILLED NURSING ORDERS

Visit Frequency / Duration	RN visits: _____ x/week for _____ weeks OR range: _____
Assessment Focus	☐ Cardiopulmonary ☐ Neuro ☐ GI/GU ☐ Pain ☐ Skin/Wound ☐ Safety ☐ Other
Medication Orders	☐ Reconcile medications ☐ Teach regimen ☐ Administer as ordered ☐ Monitor side effects
Wound / Device Orders	Location/type: _____ Cleanse: _____ Dressing: _____ Frequency: _____
Teaching / Notify Parameters	Teaching: _____ Notify provider if: _____

6. INFUSION THERAPY REFERRAL / ORDERS

Complete this section for home infusion therapy nursing support. Include pharmacy orders, medication profile, access/device information, recent labs, and first-dose or tolerance documentation when applicable.

Medication / Drug	Dose / Concentration	Route	Frequency	Duration	Start Date

6A. INFUSION DETAILS

Infusion Method	☐ IV push ☐ Gravity ☐ Pump ☐ Elastomeric ☐ Other: _____	**Medication Supplied By**	☐ Pharmacy ☐ Facility ☐ Patient ☐ Other
First Dose	☐ Given and tolerated ☐ To be given at home ☐ Not required Date: _____	**Premedication Orders**	
Vascular Access	☐ PIV ☐ PICC ☐ Midline ☐ Port ☐ Other: _____	**Access Details**	Size/lumen/site/date placed: _____
Flush / Lock Orders	NS: _____ mL before/after Heparin: _____ units/mL, _____ mL Frequency: _____	**Dressing / Cap Change**	Dressing q____ days / PRN; cap change q____ days / PRN
Infusion Pharmacy	Name: _____ Phone: _____ Fax: _____	**Pharmacist / Contact**	

6B. MONITORING, LABS, AND ADVERSE REACTION ORDERS

Monitoring / Parameters	Vital signs: ☐ pre ☐ during ☐ post; monitor for adverse reaction, line complications, infiltration/extravasation, infection, and therapy response.
Lab Orders	Labs: _____ Frequency: _____ Draw from: ☐ peripheral ☐ line if permitted Results to: _____
Adverse Reaction Orders	☐ Stop infusion ☐ Maintain IV access ☐ Notify ordering provider/pharmacy ☐ Call 911 for severe reaction/anaphylaxis.
Additional / Special Instructions	

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7. REQUIRED / RECOMMENDED ATTACHMENTS

☐ Patient demographics / face sheet	☐ Current medication list
☐ Recent H&P, progress note, discharge summary, or relevant clinical note	☐ Insurance card / authorization information if applicable
☐ Physician orders / prescription	☐ Diagnosis and medical necessity documentation
☐ Recent labs relevant to therapy	☐ Infusion pharmacy orders and contact information
☐ Line placement report / access documentation	☐ Wound measurements/photos if wound care requested
☐ Allergy list and reaction history	☐ Hospital discharge instructions if post-discharge referral

8. ALLERGIES, SAFETY, AND HOME READINESS

Allergies / Reactions	☐ No known allergies ☐ Allergies listed: _____
Infection / Isolation	☐ None known ☐ Contact ☐ Droplet ☐ Airborne ☐ Other precautions: _____
Fall / Safety Risks	☐ None known ☐ Fall risk ☐ Oxygen ☐ Pets ☐ Smoking ☐ Other: _____
Homebound / Access Notes	Home entry, caregiver availability, mobility, transportation, or access concerns: _____
Caregiver / Teachable Person	Name: _____ Relationship: _____ Phone: _____
Emergency Plan	☐ Patient/caregiver instructed to call 911 for emergency symptoms. Provider-specific instructions: _____

9. PROVIDER CERTIFICATION / ORDERS

By signing below, the ordering provider certifies that the services requested are medically necessary, that the patient requires skilled nursing assessment/intervention as ordered, and that St. Bridget Care Solutions may contact the provider, referral source, pharmacy, payer, and patient/caregiver for care coordination and referral intake. Additional payer-specific certification, prior authorization, or plan-of-care signatures may be required.

Provider Name		**Credentials**	
Signature		**Date**	
NPI		**Phone**	
Fax / Secure Email		**Practice Name**	

REFERRAL SUBMISSION INSTRUCTIONS

Fax or securely transmit this completed referral form with required clinical attachments to St. Bridget Care Solutions. Phone: 410-205-9887 | Fax: 410-841-6030 | Secure Email: SBCS@stbridgetcare.com | Website: stbridgetcare.com. For urgent referrals or same-day review, call to confirm receipt after secure transmission.

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10. ST. BRIDGET CARE SOLUTIONS INTAKE USE ONLY

Referral Received		**Received By**		**Method**	☐ Fax ☐ Email ☐ Phone ☐ Portal
Eligibility Verified	☐ Yes ☐ No ☐ Private Pay	**Auth Needed**	☐ Yes ☐ No	**Auth #**	
Clinical Review	☐ Accepted ☐ Pending info ☐ Unable to accept	**RN Assigned**		**SOC Date**	
Priority Level	☐ Routine ☐ Urgent ☐ Same-day	**Payer Type**	☐ Private Pay ☐ Commercial ☐ Other	**SOC Target**	
Missing Items	☐ Orders ☐ Demographics ☐ Medication list ☐ Clinical note ☐ Labs ☐ Pharmacy info	**Follow-up Date**		**Initials**	
Outcome	☐ Scheduled ☐ Referred elsewhere ☐ Patient declined ☐ Other: _____	**Reason / Notes**		**Initials**	

INTERNAL NOTES / FOLLOW-UP LOG

Date	Initials	Contacted	Notes / Follow-Up Action

REFERRAL CLOSURE

Disposition	☐ Accepted and scheduled ☐ Pending additional documentation ☐ Unable to accept ☐ Patient declined
Reason / Notes	
Closed By / Date	