REFERRAL/PATIENT INFORMATION SHEET

REFERRAL INFORMATION

Date of Referral: | Person Receiving Referral: | Referral Source: | Phone #:

Patient Name (First, MI, Last):

Home Address: | Home Phone #:

Patient at:
☐ Home ☐ Nursing Home ☐ Assisted Living Facility ☐ Hospital ☐ Other: ______

Name of Facility: | Room #:

Facility Address: | Facility Phone #: | Pharmacy Phone #:

Direction to Home:

DOB: | Age: | Sex: ☐ M ☐ F | Marital Status: ☐ M ☐ W ☐ D ☐ S | Race: | English primary language? ☐ Yes ☐ No

Primary Family/Caregiver contact: | Relationship:

Address: | Phone #: | Other: Cell

DPOA Name: *(if applicable)* | Phone #: | Other: Cell

PATIENT INFORMATION

Primary Diagnosis: | Other Diagnoses/co-morbidities:

Recent hospital stay? ☐ Yes ☐ No | Reason and Dates: | Hospital Name:

Attending Physician Name: | Phone #: | Fax #:

Physician Address: | Does Attending Physician want Hospice Physician to Follow? ☐ Yes ☐ No

Patient history/changes in condition leading to referral:

Equipment/special needs for admission: | Patient has Pacemaker? ☐ Yes ☐ No
Patient has ICD? ☐ Yes ☐ No

Funeral Home | Address: | Phone #:

Church | Address | Phone #:

Patient has pets in home? ☐ Yes ☐ No | Patient/family smokers? ☐ Yes ☐ No | Admission Priority Code:

Safety Issues: | Patient is a Veteran? ☐ Yes ☐ No

INSURANCE INFORMATION

PRIMARY: ☐ **Medicare** ☐ **Medicaid** ☐ **Other:** ______

Medicare #: | Social Security #: | Medicaid #:

Other Insurance Coverage - Insured Name: | Co-pay/coverage benefits/limits or VA:

Group Policy #: | Insured Social Security #:

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