

# 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: <input type="checkbox"/> Home <input type="checkbox"/> Nursing Home <input type="checkbox"/> Assisted Living Facility <input type="checkbox"/> Hospital <input type="checkbox"/> Other:			
Name of Facility:			Room #:
Facility Address:		Facility Phone #:	Pharmacy Phone #:
Direction to Home:			

DOB:	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Marital Status: <input type="checkbox"/> M <input type="checkbox"/> W <input type="checkbox"/> D <input type="checkbox"/> S	Race:	English primary language? <input type="checkbox"/> Yes <input type="checkbox"/> No
Primary Family/Caregiver contact:			Relationship:		
Address:			Phone #:	Other: Cell	
DPOA Name: <i>(if applicable)</i>			Phone #:	Other: Cell	

## PATIENT INFORMATION

Primary Diagnosis:	Other Diagnoses/cc-morbidities:		
Recent hospital stay? <input type="checkbox"/> Yes <input type="checkbox"/> No	Reason and Dates:		Hospital Name:
Attending Physician Name:		Phone #:	Fax #:
Physician Address:		Does Attending Physician want Hospice Physician to Follow? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Patient history/changes in condition leading to referral:			
Equipment/special needs for admission:		Patient has Pacemaker? <input type="checkbox"/> Yes <input type="checkbox"/> No	Patient has ICD? <input type="checkbox"/> Yes <input type="checkbox"/> No
Funeral Home	Address:		Phone #:
Church	Address		Phone #:
Patient has pets in home? <input type="checkbox"/> Yes <input type="checkbox"/> No	Patient/family smokers? <input type="checkbox"/> Yes <input type="checkbox"/> No	Admission Priority Code:	
Safety Issues:		Patient is a Veteran? <input type="checkbox"/> Yes <input type="checkbox"/> 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 #:	

To order forms call: MED-PASS 800-433-8884