Family LifeCare

Referral Form

Fax: 260-589-3462
Ph: 800-355-2817

Referral Name: _____ Ph:_____
Referral Date: _____ Time: _____
Facility: _____

Demographics **ID#_____** (FLC Use Only)	Patient Name:_____ Date of Birth: _____ Address:_____ SSN:_____ □ M □ F City, State, Zip:_____ Alt. Contact Name:_____ Phone: _____ Alt. Contact Phone:_____ Email:_____ Relationship:_____ If in Facility: Facility:_____ Room:_____ Discharge Date:_____ Patient skilled? □ No □ Yes Skilled Benefit End Date:_____ Remaining in NF: □ No □ Yes
Diagnoses	Primary DX:_____ Secondary DX:_____ Additional DX:_____
Hospice □ **Referral**	*Supporting Criteria (please complete what information is available):* Weight Loss in last 6 months: _____lbs. Current Weight: ____lbs. Height: _____ft. _____in. = BMI_____ % Eating:_____ # of Hospitalizations in past year:_____ # of ER visits in past year:_____ O2:___liters Incontinence of: ☐ Bladder/ ☐ Bowel Sleeping:___hours/day # of Wounds:_____ Staging:_____ Needs assistance with: ☐ Bathing ☐ Dressing ☐ Feeding ☐ Toileting ☐ Transferring
Home Health □ **Referral**	**Qualifying Services:** □ Skilled nursing □ Physical therapy □ Speech therapy **Specific Orders:** □ Instruct & assess medications □ Assess & instruct disease process □ Lab work (specify) □ Wound care (specify) **Additional Services:** □ Occupational therapy □ Home health aide □ Social worker □ Other (specify)
TCM □ **Referral**	**Specific Orders:** □ Instruct & assess medications □ Lab work (specify):_____ □ Assess & instruct disease process □ Physician Appointment (specify): _____ □ Other (specify): _____
Referring Provider	Referring MD/NP/PA: _____ Phone #:_____ *Can be referred by NP/PA but orders MUST be signed by MD* Fax #: _____ Will referring physician act as patient's following physician? □ Yes □ No Attending Physician:_____ Phone #:_____ Specialist:_____ Phone #:_____
Payer Information	Health Insurance: _____ Insurance #: _____ Insured Member:_____ Insurance Phone #:_____ *FLC Only* (Can accept insurance: □ Yes □ No _____

Additional Comments:_____
_____
_____
_____
_____

FLC Staff Only

Enrollment Date:_____ Time:_____ Location:_____ FLC Rep:_____
Enrollment With: _____ Relationship: _____

_____ Insurance & Medicare Part D Card
_____ Recent labs/x-rays/scans/x-rays/scans/EKG
_____ NF-MAR, weight, diet & face sheet
_____ History & Physical
_____ Face sheet & demographics
_____ Physician orders
_____ Medication List
_____ Hospital - SBAR
_____ IV-PICC line/IV provider (home health only)