



Referral Form

Fax: 260-589-3462

Ph: 800-355-2817

Referral Name: _____ Ph: _____

Referral Date: _____ Time: _____

Facility: _____

Demographics	Patient Name: _____ Date of Birth: _____ Address: _____ SSN: _____ <input type="checkbox"/> M <input type="checkbox"/> F City, State, Zip: _____ Alt. Contact Name: _____ Phone: _____ Alt. Contact Phone: _____ Email: _____ Relationship: _____ Veteran: ___ Yes ___ No Receiving services from VA: ___ FW ___ Marion Other: _____ If in Facility: Facility: _____ Room: _____ Discharge Date: _____ Patient skilled? <input type="checkbox"/> No <input type="checkbox"/> Yes Skilled Benefit End Date: _____ Remaining in NF: <input type="checkbox"/> No <input type="checkbox"/> Yes		
ID# <small>(FLC Use Only)</small>			
Diagnoses	Primary DX: _____ Secondary DX: _____ Additional DX: _____		
Hospice <input type="checkbox"/> Referral	<i>Supporting Criteria (please complete what information is available):</i> 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 <input type="checkbox"/> Referral <input type="checkbox"/> In-Home Palliative Care	Qualifying Services: <input type="checkbox"/> Skilled nursing <input type="checkbox"/> Physical therapy <input type="checkbox"/> Speech therapy	Specific Orders: <input type="checkbox"/> Instruct & assess medications <input type="checkbox"/> Assess & instruct disease process <input type="checkbox"/> Evaluate & Treat <input type="checkbox"/> Lab work (specify) <input type="checkbox"/> Wound care (specify)	Additional Services: <input type="checkbox"/> Occupational therapy <input type="checkbox"/> Home health aide <input type="checkbox"/> Social worker <input type="checkbox"/> Other (specify)
TCM <input type="checkbox"/> Referral	Specific Orders: <input type="checkbox"/> Instruct & assess medications <input type="checkbox"/> Lab work (specify): _____ <input type="checkbox"/> Assess & instruct disease process <input type="checkbox"/> Physician Appointment (specify): _____ <input type="checkbox"/> Other (specify): _____		
Referring Provider	Referring MD/NP/PA: _____ <i>Can be referred by NP/PA but orders MUST be signed by MD</i> Will referring physician act as patient's following physician? Attending Physician: _____ Specialist: _____		Phone #: _____ Fax #: _____ <input type="checkbox"/> Yes <input type="checkbox"/> No Phone #: _____ Phone #: _____
Payer Information	Health Insurance: _____ Insured Member: _____ For Medicare Part D: Pharmacy name _____		Insurance #: _____ Insurance Phone #: _____ Phone #: _____

Additional Comments: _____

FLC Staff Only		
Enrollment Date: _____	Time: _____	Location: _____
Enrollment With: _____		FLC Rep: _____
Relationship: _____		
_____ Insurance & Medicare Part D Card	_____ History & Physical	_____ Medication List
_____ Recent labs/x-rays/scans/x-rays/scans/EKG	_____ Face sheet & demographics	_____ Hospital - SBAR
_____ NF-MAR, weight, diet & face sheet	_____ Physician orders	_____ IV-PICC line/IV provider (HHC)
		_____ IV Order (HHC)