CRS_____

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:_____ Veteran: ☐ Yes ☐ No Receiving services from VA: ☐ FW ☐ Marion Other: _____ 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 **□ In-Home Palliative Care**	**Qualifying Services:** □ Skilled nursing □ Physical therapy □ Speech therapy **Specific Orders:** □ Instruct & assess medications □ Assess & instruct disease process □ Evaluate & Treat □ 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): _____
□ Palliative NP Consult Referral	**Specific Orders:** □ Palliative Care NP Consult Evaluate and Treat Need: □ EKG □ Lab work □ H & P □ Med list □ Discharge summary if in hospital
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 #:_____ Medicare Part D Pharmacy name:_____ Phone #: _____

Additional Comments:_____
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