Referral Form

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

Caller's Name: _____ Ph:_____

Facility/Doctor: _____

Date: _____ Time: _____ CRS: _____

Services requested: □ **Hospice** □ **Home Health** □ **In-Home Palliative Care** □ **Palliative NP Consult** **ID#** **(FLC use only)** FH _____ HH_____ IHPC (circle) PC _____	Name:_____ Birthdate: _____ Address:_____ SSN:_____ □ M □ F City/State/Zip:_____ Alt Contact:_____ Phone: _____ Alt Contact Ph #:_____ Receiving services from VA: ☐ Yes ☐ No Relationship:_____ If in Facility (name):_____ Room:_____ Discharge Date:_____ Patient skilled? □ No □ Yes; skilled benefit end date:_____ Remaining in NF: □ No □ Yes Primary DX:_____ Secondary DX:_____ Additional DX:_____
Home Health/ 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) _____ _____
Palliative NP Consult	**Specific Orders:** ☐ Palliative Care NP Consult Evaluate and Treat Need: ☐ EKG ☐ Lab work ☐ H & P ☐ Med list ☐ Discharge summary if in hospital
Providers	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 Primary Physician:_____ Phone #:_____ Specialist:_____ Phone #:_____
Payer Information	Insurance: _____ Insurance #: _____ Insured Member:_____ Insurance Phone #:_____ Medicare Part D Pharmacy:_____ Phone #: _____

Additional Comments:_____

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