



# Home Care Services/Hospice Referral Form

Please fax the completed form to (517) 841-6987, or call us at (517) 841-6982 or toll free 1-888-821-3256.

Required Patient Information (please print)

Today's Date: \_\_\_\_\_

Patient's Full Name: \_\_\_\_\_  Male  Female

Date of Birth: \_\_\_\_\_ SSN: \_\_\_\_\_

Contact Person (patient or other): \_\_\_\_\_ Contact Phone: \_\_\_\_\_

Place of Service:  Home  Other Address: \_\_\_\_\_

Primary Diagnosis: \_\_\_\_\_

Insurance (list or attach face sheet):  Medicare  Medicaid  Other: \_\_\_\_\_

### Referral Information

<input type="checkbox"/> Home Care	<input type="checkbox"/> Nurse to assess	<input type="checkbox"/> Telehealth -
	<input type="checkbox"/> Physical Therapy to Evaluate and Treat	(CHF, COPD, CAD/MI, CABG)
	<input type="checkbox"/> Speech Therapy to Evaluate and Treat	
<input type="checkbox"/> Hospice	Terminal Illness: _____	
	<input type="checkbox"/> No Obligation Home Information Visit	
	<input type="checkbox"/> Nurse to Start Hospice Care	
<input type="checkbox"/> Personal Care Services (Private Pay, Private Duty)	<input type="checkbox"/> Call Patient for Service Needs	
	<input type="checkbox"/> Call Other:	
	_____	_____
	Name	Relationship Contact Number
<input type="checkbox"/> Home Medical Equipment (Fax: 517-780-3816)	Height: _____ Weight: _____	<input type="checkbox"/> Wheelchair <input type="checkbox"/> Hospital Bed
	<input type="checkbox"/> Oxygen O2 Saturation: _____ Test Date: _____	
	<input type="checkbox"/> Respiratory Assessment (Comprehensive Pulse Oximetry, Auscultation, Blood Pressure)	
	<input type="checkbox"/> Lifeline: Desires a call? Y / N or Mail information? Y / N	
	Direct questions on Lifeline services to (517) 788-4725. Free install code: _____	
	3 <sup>rd</sup> party fax notification is sent if patient incident.	
	<input type="checkbox"/> Other: _____	

Additional Orders/Special Instructions: \_\_\_\_\_

### Referral Contact Information (please print)

Referral Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

### Referring Physician Information (please print)

Physician Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**Thank you for choosing Allegiance Health.**