HARBOR | HOSPICE

Referral Form

Referral Date: _____ MR #: _____

Referral Time: _____ Legals Sch. Date: _____

Legals Sch. Time: _____

Referral Source: _____ SOC Date: _____

Referral Phone #: (_____) _____ SOC Time: _____

Referral Take By: _____ Admit Nurse: _____

Patient Information HH Location: _____

☐ Male ☐ Female Priority Level: ☐ 1 ☐ 2 ☐ 3

Name: _____ Age: _____ DOB: _____ SS #: _____-____-_____

Physical Address: _____ City/Zip: _____

DX: _____ ICD-9: _____ Phone #: (_____) _____

Allergies, If Available: _____ Transferred From: _____

Primary Caregiver: _____ Phone #: (_____) _____ Relationship: _____

Caregiver Address: _____

Physician Referring: _____ Phone/Fax #: (_____) _____

NPI #: _____ *Please check which physician is writing orders, if more than one is listed

License #: _____ License # Verified ☐ Yes (Copy of TBME verification maintained)

Attending Physician: _____ Phone/Fax #: (_____) _____

NPI #: _____ *Please check which physician is writing orders, if more than one is listed

License #: _____ License # Verified ☐ Yes (Copy of TBME verification maintained)

Six Month Prognosis? ☐ Yes ☐ No Pain Management: ☐ Yes ☐ No

Medicare #: _____ Medicaid #: _____

Insurance: _____ Policy #: _____ Group #: _____

Phone #: (_____) _____ Employer: _____

DME in Home: ☐ Yes ☐ No Company Phone #: (_____) _____

DME to be Ordered: _____ By: _____

In Hospital or Nursing Facility?: _____ Room #: _____

Phone #: (_____) _____ D/C Date/Time (if available): _____

If in Nursing Facility: ☐ Medicare ☐ Medicaid ☐ Private Pay ☐ Room

Other information and/or contacts: _____