

Please complete and fax the following information to (214) 445-3900. For assistance, call (888) 800-5311.

PATIENT INFORMATION

Please check the type of referral: Home Health Hospice

Patient Name: Date of Referral:

Phone: Sex: Male Female

Address: SSN:

City: State: ZIP Code: DOB:

Referring Physician: Medicare/Insurance #:
(or attach copy)

Home Health only: Primary Contact Name:

Primary Dx: Primary Contact Phone:

Secondary Dx: Relationship to Patient: Self Other

Hospice only: Referral Contact Name:

Hospice Dx: Referral Contact Phone:

Has hospice been discussed with the patient/family? Y N Referral Contact Email:

DOCUMENTATION

Please check each document, if included:

Home Health only:

Please include the following:

- Face-to-Face Encounter
- H&P
- Current Medication List
- Patient Face Sheet (Demographics)
- Last Visit Notes

Hospice only:

Please include the following:

- Patient Face Sheet (Demographics)
- Pathology Reports
- H&P
- Discharge Summary
- Last Visit Notes
- Labs
- Medicare/Medicaid/Commercial Insurance

CARE-AT-HOME DIRECTIVES

SKILLED SERVICES & INTERVENTIONS (Home Health only):

Please describe services the nurse or therapist will perform.

- Skilled Nursing:
- Physical Therapy:
- Speech Therapy:
- Occupational Therapy:
- Social Work:
- Home Health Aide:
- Palliative Care:

ORDERS (Hospice only):

- Evaluate and admit patient to Intrepid USA Hospice.
- I wish to serve as Attending Physician if the patient chooses.
 - If selected as Attending Physician, I would like to manage all care of the patient.
 - If selected as Attending Physician, I would prefer for the Hospice Physician to manage pain and symptoms.
 - I will sign the death certificate.
 - I would prefer the Hospice Physician sign the death certificate.
- I do not wish to serve as Attending Physician.

SIGNATURE

For Physicians: Please sign below to authorize Intrepid USA Healthcare Services to evaluate and admit patient, if eligible.

Physician Signature:

Printed Name: Date: