IntrepidUSA
Healthcare & Hospice at Home

HOME HEALTH/HOSPICE QUICK REFERRAL

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: .....
Phone: .....
Address: .....
City: ..... State: ..... ZIP Code: .....
Referring Physician: .....

Home Health only:

Primary Dx: .....
Secondary Dx: .....

Hospice only:

Hospice Dx: .....
Has hospice been discussed with the patient/family? ❑ Y ❑ N

Date of Referral: .....
Sex: ❑ Male ❑ Female
SSN: .....
DOB: .....
Medicare/Insurance #: .....
(or attach copy)
Primary Contact Name: .....
Primary Contact Phone: .....
Relationship to Patient: ❑ Self ❑ Other .....
Referral Contact Name: .....
Referral Contact Phone: .....
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: .....