Hospice of Davidson County, INC. Referral Form

Date:________________________________ **Person Taking Referral**:______________________________________

Patient Information

Patient ID #:________________________________ ☐ **HOME CARE** ☐ **HHH**

Patient's Name:____ ☐**Male** ☐**Female**

DOB/Age:_________________________/________ **SS#**:____

Address:____ **Hospice Dx**:______________________________________

____

Home#:______________________________ **Assessment Date**:____________________ **Time**:_____________

☐**RN Notified** ☐**SW Notified**

Cell#:_______________________________

Caregiver Information

Caregiver Name:_______________________________________ Home #:_____________________________________
(if different from above)

Relationship to patient:__________________________________ Work #:_____________________________________

Address the same as above: ☐Yes ☐No (if no, complete below)

Cell #:______________________________________

____

____ **Pt &/or CG is aware of referral:** ☐**Yes** ☐**No**

Attending Physician Information

Attending Physician:____ Phone #:________________________________

Specialty:____ After Hr #:_______________________________

Address:____ FAX #:__________________________________

____

6 Month or Less Prognosis? ☐**Yes** **Nurse Signature**:____

Date Verified by Nurse:____

☐*MD notified if patient NOT ADMITTED to Hospice Services*

Referral Source Information

Name of person calling in referral:____________________________________ **Phone #**:________________________

Relation/position to patient:____________________________ **Agency/MD/Hospital**:___________________________

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Benefit Information

Patient has had Previous Hospice Care: ☐Yes ☐No ☐ N/A (*if yes, answer next question*)
Current Benefit period patient is in: ☐1 ☐2 ☐≥3 (***if ≥3, billing to notify Quality Dept***)

Person verifying prior Hospice and previous benefit period:______________________________ Date:__________

Lana Riemann, MD Verbal Cert. Date:________________ Nurse Signature:____________________________
Medical Director

Insurance Information

Check all that apply: **☐Medicare ☐Medicaid ☐Private Insurance ☐No Insurance**

Enter in all policy numbers:

Medicare:____ Medicaid:____

Private Insurance Co.: ____

If Private Insurance, include Policy #:____

Hospitalization/ Home Health/ Other Hospice Information

Name of Hospital:_____________________________ Admit Date:______________ Discharge Date:______________

Equipment Needed:____

Ordered On-line ☐ Yes *or* ☐ Order Called –In to AHC Spoke to _________________________ at AHC to place order

Home Health Agency Involved? ☐Yes ☐No If Yes, Name of Agency:____

CAP Services Provided? ☐Yes ☐No PCS Services Provided? ☐Yes ☐No

Other Hospice Agency Involved: ☐Yes ☐No If Yes, Name of Agency:____

Contact Person at Other Hospice & phone #:____

☐Pt plans to **TRANSFER** Hospice Benefit to HODC from other Hospice Agency
☐Pt has **REVOKED** current Hospice Benefit with other Hospice Agency

Additional comments:
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