Home Healthcare Hospice & Community Services
HCS services.org

# Patient Referral Form

## Fax to 603-357-2545

Date: _____ Referral Source: _____ Phone: _____

Patient Name: _____ DOB: _____ Sex: _____ SSN: _____

Address: _____

Phone: _____ Lives alone: ☐ Lives with: _____

Contact Person: _____ Relationship: _____ Phone: _____

Primary Care Provider: _____ Phone: _____

## Requested Services:

☐ **Home Care Orders:** ☐ RN ☐ PT

Additional Services: (These services cannot be stand alone services for home care)

☐ OT ☐ SW ☐ HHA

☐ Wound Care *(Wound vac requires vendor: _____)*

☐ IV Therapy *(IV Therapy requires vendor: _____)*

☐ **Palliative Care** (Nursing and Social Work)

☐ **Hospice Care**

☐ Oxygen - Liters per minute: _____

☐ DME: ☐ Commode ☐ Hospital Bed ☐ Overbed Table

Pharmacy: _____

CADD Pump? ☐ Yes ☐ No Vendor: _____

Other: _____

***To complete this referral, the following documents are required.***
***Please Fax:***

☐ Patient Demographics
☐ Insurance information
☐ MD Orders Signed by Attending
☐ Medication List
☐ Recent History & Physical
☐ Discharge Summary & Visit Note
☐ Skilled Need **(Face to face information — Medicare Only; not needed for Hospice)**

Referring Provider Signature: _____

24/7 Intake Admissions and Referrals: 1-800-541-4145 • **Referral Fax: 603-357-2545**