Express Referral Form

THIS IS A TRINITY HEALTH-AFFILIATED REFERRAL

Please COMPLETE this form, add all REQUIRED DOCUMENTATION and FAX to our Customer Care Center

HOME CARE & HOSPICE REFERRALS FAX: 833-854-3579

REFERRAL FROM:

Name ________________________________

Company ________________________________

Phone ______________________ Fax ______________________

Date ____________________

Patient's name ________________________________ D.O.B. ______________

Address ________________________________

Phone ________________________

Reason for referral (Please include primary diagnosis and any secondary diagnoses)

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Expected discharge date ____________________ Start of care date ______________

Physician to follow ________________________ Phone ______________

Has the patient been discharged from a facility in the last 14 days? Y N

Facility name ________________________________

City/State ________________________ Discharge date ______________

ALERT:

YOUR PATIENT'S ADMITTANCE INTO OUR CARE WILL BE DELAYED IF FIELDS ARE LEFT INCOMPLETE OR REQUIRED FORMS ARE NOT ATTACHED. THANK YOU FOR YOUR PARTNERSHIP IN ENSURING SWIFT PATIENT CARE.

REQUIRED DOCUMENTATION

- ☐ **Demographic sheet, including insurance information**
- ☐ **H & P** (including secondary diagnoses/comorbidities)
- ☐ **Physician signature** (on this form or on attached physician order)
- ☐ **Progress notes**
- ☐ **Current medication list**

Also: A discharge summary is required for referrals from skilled nursing facilities.

SERVICES REQUESTED

☐ **HOME CARE:** ○ NURSING ○ PT ○ OT ○ SPEECH LANGUAGE PATHOLOGY ○ SOCIAL WORK ○ WOUND CARE ○ INFUSION ○ HOME HEALTH AIDE

☐ **HOSPICE**

☐ **COMMUNITY-BASED PALLIATIVE CARE** (limited service area at this time; we will review referral and follow up)

HOSPICE ONLY:

Will physician remain attending during hospice services? Y N

INFUSION AND WOUND CARE PATIENTS ONLY:

Teachable caregiver? Y N Name of caregiver ________________________________

Relationship ________________________ Phone ________________________

Ordered by:

Physician printed name ________________________ Physician signature ________________________ Date ______________

Or: Verbal order from Dr. ____________________ obtained by ____________________ (printed name) Signature ____________________

Thank you for choosing us. We are honored to earn your trust. Please contact us if you have any questions.