



Home Care Services/Hospice Referral Form

Please fax the completed form to (517) 841-6987, or call us at (517) 841-6982 or toll free 1-888-821-3256.

Required Patient Information (please print)

Today's Date: _____

Patient's Full Name: _____ Male Female

Date of Birth: _____ SSN: _____

Contact Person (patient or other): _____ Contact Phone: _____

Place of Service: Home Other Address: _____

Primary Diagnosis: _____

Insurance (list or attach face sheet): Medicare Medicaid Other: _____

Referral Information

<input type="checkbox"/> Home Care	<input type="checkbox"/> Nurse to assess	<input type="checkbox"/> Telehealth -
	<input type="checkbox"/> Physical Therapy to Evaluate and Treat	(CHF, COPD, CAD/MI, CABG)
	<input type="checkbox"/> Speech Therapy to Evaluate and Treat	
<input type="checkbox"/> Hospice	Terminal Illness: _____	
	<input type="checkbox"/> No Obligation Home Information Visit	
	<input type="checkbox"/> Nurse to Start Hospice Care	
<input type="checkbox"/> Personal Care Services (Private Pay, Private Duty)	<input type="checkbox"/> Call Patient for Service Needs	
	<input type="checkbox"/> Call Other:	
	_____	_____
	Name	Relationship Contact Number
<input type="checkbox"/> Home Medical Equipment (Fax: 517-780-3816)	Height: _____ Weight: _____	<input type="checkbox"/> Wheelchair <input type="checkbox"/> Hospital Bed
	<input type="checkbox"/> Oxygen O2 Saturation: _____	Test Date: _____
	<input type="checkbox"/> Respiratory Assessment (Comprehensive Pulse Oximetry, Auscultation, Blood Pressure)	
	<input type="checkbox"/> Lifeline: Desires a call? Y / N or Mail information? Y / N	
	Direct questions on Lifeline services to (517) 788-4725. Free install code: _____	
	3 rd party fax notification is sent if patient incident.	
	<input type="checkbox"/> Other: _____	

Additional Orders/Special Instructions: _____

Referral Contact Information (please print)

Referral Name: _____ Phone: _____ Fax: _____

Referring Physician Information (please print)

Physician Name: _____ Phone: _____ Fax: _____

Thank you for choosing Allegiance Health.

Confidential Information: The information contained in this facsimile is privileged and confidential, intended for the use of the addressee/recipient or the employee or agent responsible for delivering this information to the intended recipient. You are hereby notified that any disclosure, copying, distribution, or the taking of any action in reliance of the information contained in this facsimile is strictly prohibited. If you have received this message in error, please immediately notify the sender at the phone number above, permanently delete this facsimile and destroy any copies of this information in your possession.