Allegiance HEALTH

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

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