

FAST TRACK HOME HEALTH & HOSPICE REFERRAL WORKSHEET

To make a referral - Central Intake: P: 866-591-8843 or F: 207-400-8894 or F: 207-400-8895

PATIENT NAME: _____ Date: _____

Address: _____ Town: _____ Zip Code: _____

DOB: ____/____/____ SSN: _____ - _____ - _____ Home Phone: _____

Emergency Contact/Phone: _____

PAYER SOURCE: Medicare #: _____

Insurance Company #: _____

PMH: CAD CHF COPD CVA Dementia Diabetes
 Falls OA Osteoporosis Parkinson's Other: _____

SERVICES REQUESTED (Please select skilled nursing, physical therapy or speech therapy to admit patient)

| | | |
|---|--|---|
| <input type="checkbox"/> Skilled Nursing | <input type="checkbox"/> Physical Therapy | <input type="checkbox"/> Speech Therapy |
| <input type="checkbox"/> Occupational Therapy | <input type="checkbox"/> Social Work (MSW) | <input type="checkbox"/> Home Health Aide |
| <input type="checkbox"/> Telehealth | <input type="checkbox"/> Hospice | |

Primary Diagnosis/Reason for Referral: _____

Specific Orders (i.e., wound care, medication teaching, gait training, assessment):

Name and Number of person sending in this referral: _____

Primary Care Physician Name (Print): _____

Physician Office Phone Number: _____ Fax: _____

Physician Office Address: _____

Please include these documents: Face Sheet/Demographic Page Last Visit Note
 Medication List H&P/Discharge Summary