

Fax Cover Sheet

Date:

Referral for:

Home Care

Fax #: 888-207-3106

Hospice Care

Fax #: 877-201-0104

From:

Practice/Physician, Name of Contact at Office

Fax #:

Phone#:

Number of pages including cover sheet:

Confidentiality Notice

The information contained in this facsimile message is confidential information belonging to the sender, intended only for the use of the individual or entity named above. If you are not the intended recipient, or the employee or agent responsible for delivering this message to the intended recipient, you are hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If you have received this communication in error, please notify us immediately by telephone to arrange for the return of the original document to us. Thank You.

Baystate Home Health

Baystate Hospice

Phone 413-798-6411

Home Health Fax 888-207-3106

Hospice Fax 877-201-0104

Referring Physician:

Referral for:

- HOME CARE
- HOSPICE

Patient Name/DOB: _____

Date of Referral: _____

Requested Home Visit Date: _____

MD Orders

Primary Diagnosis: _____

Co-Morbidities: _____

Allergies: _____

Specific Orders for Treatment: _____

Hospice

DNR/CCP: _____

Primary Diagnosis: _____

Secondary/Comorbid Diagnosis: _____

Skilled Nursing

- Teach Signs & Symptoms of Disease Process
- Assess Vital Signs
- Safety
- Nutrition/External Feedings
- Pain Management Education
- DM Monitoring/Teaching
- IV Medication _____

- Medication Education/Reconciliation
- Perform Wound Care/Skin Assessment

Physical Therapy

- Improve ROM
- Increase Endurance
- Evaluate Home Safety
- Fall Prevention
- DME Education

Speech Therapy

- Assess Swallowing
- Feeding Precautions
- Perform Bedside Swallow Evaluation

Additional Services

- Occupational Therapy
- Medical Social Worker
- Home Health Aide

PLEASE ATTACH PATIENT'S DEMOGRAPHICS SHEET, MEDICATION LIST, INSURANCE INFORMATION, and FACE TO FACE OFFICE VISIT NOTE supporting the need for this referral.