Fax Cover Sheet

Date: ..............................................................................................................

Referral for:

☐ Hospice/Palliative Care
  Fax #: (413)-794-6412

☐ Home Care
  Fax #: (413)-794-6475

From: ............................................................................................................
  Practice/Physician, Name of Contact at Office

Fax #: ..............................................................................................................

Phone#: .......................................................................................................  

Number of pages including cover sheet: ................

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**Baystate Home Health**  
**Baystate Hospice**

**MD Orders**

| Referring Physician: | □ HOME CARE  
|□ HOSPICE  
|□ PALLIATIVE |

**Hospice/Palliative**

| DNR/CCP:  
|Primary Diagnosis:  
|Secondary/Comorbid Diagnosis:  
|If Non-Cancer Diagnosis, list symptoms: (e.g. weight loss; appetite, endurance; functional status; pain, etc) |

**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
  Specific MSW needs:
- Home Health Aide
- Volunteer
- MAP Eval

**PLEASE ATTACH PATIENT’S DEMOGRAPHICS SHEET, MEDICATION LIST, INSURANCE INFORMATION and FACE TO FACE ENCOUNTER FORM**