

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

Telephone..... 413.794.6411

Home Care Fax..... 413.794.6475

Hospice/Palliative Care Fax..... 413.794.6412

Referring Physician:

Referral for:

- HOME CARE
- HOSPICE
- PALLIATIVE

Patient Name/DOB: _____

Date of Referral: _____

Requested Home Visit Date: _____

MD Orders

Primary Diagnosis: _____

Co-Morbidities: _____

Allergies: _____

Specific Orders for Treatment: _____

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**