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: .....

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