crossroads HOME HEALTH & HOSPICE

REFERRAL FORM

San Francisco Branch
1109 Vicente St. #101 San Francisco, Ca 94116
Tel: 415-682-2111 **Fax**: 415-682-2112

East Bay Branch
7700 Edgewater Dr. #225 Oakland, Ca 94621
Tel: 510-638-8033 **Fax**: 510-638-8034

Please complete all sections below and include a copy of demographics, last progress/visit note, medication list and past medical history

1. Patient Demographics

Patient Name: *(Last Name, First):* _____

Patient Date of Birth: _____/_____/_____

Patient Address: _____

_____

Patient Telephone: (_____) _____-_____

Patient's Sex: ☐ Male ☐ Female

Patient SSN: _____ - _____ - _____

Patient Allergies: _____

Primary Caregiver / Emergency Contact or Durable Power of Attorney:

Name: _____ Tel: (_____) _____-_____

2. Payer Information

Patient's Primary Insurance

Medicare #: _____

Medicaid (Medi-Cal) #: _____

HMO / Commercial Insurance:

Payer Name: _____

Policy # _____

COMPLETE EITHER SECTION 3 OR 4

3. Home Health and/or Palliative Care Order

☐ **Evaluate and if appropriate, admit and treat under Home Health**

Please select the discipline(s) the patient should be evaluated for:

☐ **Skilled Nursing** ☐ **Occupational Therapy** ☐ **Medical Social Worker**

☐ **Physical Therapy** ☐ **Speech Therapy** ☐ **Home Health Aide**

Would this patient benefit from a palliative care consult?

☐ Yes ☐ No

For Medicare Patients: Please include Face-to-Face Encounter Note, physician progress note and/or Discharge Summary documentation with the following elements that supports the need for home health services:

- ☐ Reason for skilled need (why home health is medically necessary)
- ☐ Homebound status
- ☐ Name of provider *(MD, DO or DPM)* who will be responsible for following the patient's plan of care while receiving Home Health services

4. Hospice Order

☐ **Evaluate and if appropriate, Admit to Hospice**

Does the patient need immediate pain or symptom management and/or oxygen? If yes, please make the appropriate selection(s) below

☐ Patient needs immediate pain management

☐ Patient needs immediate symptom management

☐ Patient needs Oxygen _____ Liters per minute

5. Diagnosis

Primary Diagnosis or Condition for which patient is being referred to service(s):

_____

_____

6. Referring Provider Signature

Referring Provider Signature: _____ Date: _____/_____ /_____

*(Signature must be from **Physician for Home Health and/or Palliative Care**, **Physician, NP or PA for Hospice**)*

Print Name of Referring Provider: _____ (indicate MD, DPM, DO, NP or PA)

Tel: (_____) _____-_____ Fax: (_____) _____-_____

FAX COMPLETED FORM TO: 415-682-2112 or 510-638-8034 OR EMAIL TO: eFAX@CROSSROADSHH.COM