# CARESTRIDES REFERRAL/PATIENT INFORMATION SHEET

## REFERRAL INFORMATION

| Date of Referral: | Person Receiving Referral: | Referral Source: | Phone #: |
|---|---|---|---|

Patient Name (First, MI, Last):

| Home Address: | Home Phone #: |
|---|---|

Patient at:
☐ Home ☐ Nursing Home ☐ Assisted Living Facility ☐ Hospital ☐ Other:

| Name of Facility: | Room #: |
|---|---|

| Facility Address: | Facility Phone #: | Pharmacy Phone #: |
|---|---|---|

Direction to Home:

| DOB: | Age: | Sex: ☐ M ☐ F | Marital Status: ☐ M ☐ W ☐ D ☐ S | Race: | English primary language? ☐ Yes ☐ No |
|---|---|---|---|---|---|

| Primary Family/Caregiver contact: | Relationship: |
|---|---|

| Address: | Phone #: | Other: Cell |
|---|---|---|

| DPOA Name: *(if applicable)* | Phone #: | Other: Cell |
|---|---|---|

## PATIENT INFORMATION

| Primary Diagnosis: | Other Diagnoses/co-morbidities: |
|---|---|

| Recent hospital stay? ☐ Yes ☐ No | Reason and Dates: | Hospital Name: |
|---|---|---|

| Attending Physician Name: | Phone #: | Fax #: |
|---|---|---|

| Physician Address: | Does Attending Physician want Hospice Physician to Follow? ☐ Yes ☐ No |
|---|---|

Patient history/changes in condition leading to referral:

| Equipment/special needs for admission: | Patient has Pacemaker? ☐ Yes ☐ No<br>Patient has ICD? ☐ Yes ☐ No |
|---|---|

| Funeral Home | Address: | Phone #: |
|---|---|---|
| Church | Address | Phone #: |

| Patient has pets in home? ☐ Yes ☐ No | Patient/family smokers? ☐ Yes ☐ No | Admission Priority Code: |
|---|---|---|
| Safety Issues: | | Patient is a Veteran? ☐ Yes ☐ No |

## INSURANCE INFORMATION

**PRIMARY:** ☐ **Medicare** ☐ **Medicaid** ☐ **Other:**

| Medicare #: | Social Security #: | Medicaid #: |
|---|---|---|
| **Other Insurance Coverage** - Insured Name: | | Co-pay/coverage benefits/limits or VA: |
| Group Policy #: | Insured Social Security #: | |