



Referral/Admission Form

PATIENT ID # _____

REFERRAL

Referral Taken By _____ Date _____ Time _____

Source _____ Family Friend Facility MD DCP Other

Admitting Type Normal Admittance Transfer from other Hospice Re-admittance Acute Admission - SRMC

Name of Facility _____ Phone # _____ Room # _____

PATIENT INFORMATION

Name _____ Phone (_____) _____ -- _____
(Last) (First) (Middle)

Address _____

City _____ State _____ County _____ Zip _____

SS# _____ DOB _____ Age _____ Sex - F M

Race: Hispanic Asian Afro-American Caucasian Native American Other
 Marital Status: Married Single Widowed Divorced Unknown
 Religion: Catholic Jewish None Other Protestant Unknown
 Living Status: Lives w/able family Hired primary caregiver Lives alone Other
 Lives w/friend Lives in a nursing home Lives with compromised caregiver SRMC

Contact Person _____ Relationship _____

Address _____ City _____ State _____ Zip _____

Home Phone # (_____) _____ -- _____ Work Phone # (_____) _____ -- _____

PHYSICIAN/DIAGNOSIS INFORMATION

Primary Diagnosis _____ ICD9 _____

Primary Physician _____ Phone# (_____) _____ -- _____

Fax # (_____) _____ -- _____

Address _____ City _____ State _____ Zip _____

BILLING INFORMATION

HMB # _____ Medicaid # _____

Private Insurance Co Name _____ Phone# (_____) _____ -- _____

ID # _____ Group # _____

Case Manager _____ Phone # (_____) _____ -- _____

DIRECTIONS

ADMISSION STATUS

Patient admitted Date _____ Time _____

Patient not admitted, reason _____

NURSING HOME PATIENTS

Medicaid Bed Yes No

Type of Bed ICF SNF

