Interim HEALTHCARE®

www.interimcares.com

Referral Form

Please include last treatment note.

HOME HEALTH
Phone: 800-439-4590
Fax: 844-442-3291

HOSPICE
Phone: 800-758-4966
Fax: 844-442-3294

PERSONAL CARE
Phone: 864-841-0445
Fax: 844-442-3295

Referral Source Contact:_____ Phone:_____

Patient Name:_____

SS#:_____ DOB:_____

Address:_____

Phone:_____

Medicare / Medicaid #:_____

Private Insurance Policy #:_____

Alternative Contact:_____ Phone:_____

Diagnosis:_____

Please Evaluate Patient For (check all that apply)

HOME HEALTH SERVICES

◯ **RN** ◯ **PT** ◯ **OT** ◯ **ST** ◯ **MSW** ◯ **Telemonitoring**

◯ **Wound Care** ◯ **Balance Builder Program**

◯ **Bridge To Hospice Program** ◯ **Lymphedema Therapy**

PERSONAL CARE SERVICES

◯ **CNA** ◯ **Companion** ◯ **RN/LPN** ◯ **Transportation** ◯ **Medication Reminders**

*Services may not be covered by insurance.

HOSPICE

◯ **Initial Orders:**
Admit to hospice services and establish Plan of Care for equipment, meds, supplies and visits based on assessment of physical, psychosocial and spiritual needs.

Certification of Terminal Illness:
I certify to the best of my knowledge and medical judgment that this patient is eligible for hospice care based on terminal diagnosis and prognosis of 6 months of less, if the disease runs its normal course.

Print Physician Name_____

Physician Signature_____

Date_____