grace house
A COMFORT CARE HOME
NO ONE DIES ALONE.

Hospice/Provider Referral Form

Hospice:

Referral Contact: **Contact Phone:**

Contact email:

Name:_____ **Phone:** _____

Address: _____

SSN: _____ **Date of Birth:** _____

Age: _____ **Gender:** _____ **Ethnicity:**_____

Present Location of resident (Hospital, home, etc.): _____

Payor Source: ☐ Medicare ☐ Medicaid ☐ Medicaid Waiver ☐ None

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

Religion: **Church:**

Medical Information

Primary Diagnosis:

Other Medical History:

History of treatment:

Allergies:

Prognosis:

Any active infections (MRSA, Covid, Flu, Etc)

MRSA ☐ Yes ☐ No

TB Screening: ☐ Negative ☐ Positive

Are there concerns about medication regimen?

COMMUNITY AGENCIES ACTIVE WITH PATIENT:
Agency Name: Hospice Admit Date: Phone:
_____
_____
_____
_____

SOCIAL SERVICE ASSESSMENT / RESIDENT OR FAMILY: Please comment on each
Family relationship/support: _____

_____

Home environment (physical & social): _____

_____

_____

☐ Lives Alone ☐ Lives with others: _____

RELEVANT HISTORY, CURRENT DYNAMICS, CURRENT SITUATION:
_____
_____
_____
_____

Over the past six months have the resident, family, or hospice team noticed a problem with:
☐ Lice/Scabies: _____
☐ Bedbugs:_____
☐ Cockroaches:_____
☐ Other:_____

Sitter/Restraints-Free minimum of 24 Hours: _____

On oral medications and symptoms controlled for at least 24 hours?: ☐ Yes ☐ No

Cognitive/Emotional/Coping Status: _____
Additional problem areas: _____
History of Smoking: _____
History of alcohol use: _____
History of drug use: _____
Psych history: _____
History of domestic violence: _____

SW signature: _____ **Date**: _____

grace house
A COMFORT CARE HOME
NO ONE DIES ALONE.

PATIENT NAME: _____ DOB: _____

NURSING SUMMARY:
Vital Signs:

PPS:
Oxygen Used/Breathing Treatment: _____Rate: _____Method: _____

NUTRITION / HYDRATION:

Height: _____ Diet: _____ Weight: _____

☐ Feeds Self ☐ Assist Feed ☐ Total Feed
☐ Own Teeth ☐ Dentures

☐ Nausea ☐ Vomiting ☐ Dysphagia

Appetite: ☐ Poor ☐ Bites ☐ Full meals

Feeding Tube: Type_____ Date Inserted: _____

SENSORY/ COMFORT:

VISION:	**HEARING:**	**SPEECH:**	☐ Adequate ☐ Adequate
	☐ Good	**Sensory Aids**:	
☐ Poor	☐ Hard of Hearing	☐ Difficult	_____
☐ Blind	☐ Deaf	☐ Unable	_____
☐ Glasses	☐ Aid: L R Bilat	Language:	
☐ Contacts			

PAIN: Location:_____ Description: _____

PSYCHOSOCIAL:

Mental:	**AFFECT:**
☐ Alert	☐ Cheerful
☐ Lethargic	☐ Tearful
☐ Comatose	☐ Calm
☐ Oriented	☐ Hostile
☐ Disoriented	☐ Flat
☐ Confused	☐ Fearful
☐ Forgetful	☐ Anxious/agitated
☐ Depressed	☐ Withdrawn

Behavior:

☐ Helpful	☐ Thoughtful	☐ Mistrusting
☐ Cognitive Delay	☐ Aggressive	☐ Preoccupied
☐ Manipulative	☐ Attention Seeking	☐ Wanders
☐ Combative		

grace house
A COMFORT CARE HOME
NO ONE DIES ALONE.

ACTIVITY:
☐ Ambulatory
☐ Ambulatory w/Assist
☐ Bedbound
☐ Transfer with assist

VERBILIZATION:
☐ Non-Verbal
☐ Verbalizes only when questioned
☐ Verbalizes appropriately
☐ Other (explain) _____

HYGEINE / MOBILITY:

Persons				Equipment / #
Oral Care	☐ Independent	☐ Assist	☐ Total Dependent	_____
Bathing:	☐ Independent	☐ Assist	☐ Total Dependent	_____
Dressing:	☐ Independent	☐ Assist	☐ Total Dependent	_____

Current Equipment in Home:

ELIMINATION:

BLADDER:
☐ Continent
☐ Incontinent
☐ Retention
☐ Frequency
☐ Dribbling

BOWEL:
☐ Continent
☐ Incontinent
☐ Constipation
☐ Diarrhea
Last BM: _____

TOILETING:
☐ Independent
☐ Dependent
☐ Bedpan
☐ Catheter
☐ Foley
☐ Urostomy

Ostomy: Type:_____ Appliance:_____

SKIN:
Skin Intact: ☐ Yes ☐ No Describe any wounds/impairments: Stage: _____

Size: _____ Site: _____ Drainage: _____

Dressing type & frequency:

_____

Signature:_____ **Date**: _____