Helping Hands Hospice of Georgia, LLC 3642 Wheeler Road Augusta, GA 30909
706.432.8321
www.helpinghandshospiceofgeorgia.com

REFERRAL INTAKE FORM

Date of Referral: __________________ Delivery Date: __________________ Referral Source: ______________________

Caller Name: __________________ Phone Number: __________________ Verbal Orders and Confirmed? ( ) Yes ( ) No

PATIENT INFORMATION

Patient's Name: ____ New Patient: _______ Add On: _______

Legal Address: ____

City: ____ State: _______________ Zip: _________________

Delivery Address: (If Different from Above) ____

City: ____ State: _______________ Zip: _________________

Phone Number: ___________________________ Delivery Phone Number: (If Different) ___________________________

Date of Birth: _____________________________ Height: _____________ Weight: __________________ M ( ) F ( )

Emergency Contact: ___________________________ Relationship: _________________ Phone #: __________________

INSURANCE INFORMATION

1. Primary Insurance: ____________________________ Policy #: ______________________ Group #: ________________

Employer: ____ Policy Holder: _______________________________________

2. Secondary Insurance: _________________________ Policy #: ______________________ Group #: ________________

Employer: ____ Policy Holder: _______________________________________

3. Tertiary Insurance: ____________________________ Policy #: ______________________ Group #: ________________

Employer: ____ Policy Holder: _______________________________________

PHYSICIAN INFORMATION

Physician Name: ____ UPIN or NPI*: __________________________

Address: ____

City: ____ State: _______________________ Zip: _________________

Phone Number: ________________________ Fax Number: ______________________ Date Last Seen: ______________

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EQUIPMENT/GENERAL INFORMATION

Equipment Ordered:
____
____
____
____

Diagnosis: ____ Infectious Disease: Y ( ) N ( )

Has Patient Ever Had Same or Familiar Equipment Before? No ( ) Yes ( ) If YES, When? ___________________________

Accident Related? ( ) No ( ) Yes Accident Date: _________________ Accident Claim #: __________________________

( ) Oxygen Concentrator ( ) Oxygen Portable ( ) Oxygen Conserver ( ) Oxygen Tank

____

ABG P02: __________ 02SAT % __________ was performed on _____________ by ______________________ while patient was

( ) At Rest ( ) Exercise ( ) Sleep: The order is _______ LPM per ______ Hrs. per day per ( ) nasal cannula ( ) mask

(Date) (Testing Provider)

( ) At Rest ( ) Exercise ( ) Sleep: The order is _______ LPM per ______ Hrs. per day per ( ) nasal cannula ( ) mask

CPAP/BIPAP Settings: ___________________ ( ) Humidifier ( ) Heated Humidifier AHI _________ Date of Sleep Study:____________

Enteral Nutrition: ____________________ will be administered by ( ) syringe ( ) gravity ( ) pump for a total of ________ cals/day for _________ days per week due to participants diagnosis ______________________________ & aphhagia/dysphagia.

Pump is ordered due to: ( ) Administration rate less than 100ml. ( ) Reflux and/or Aspiration ( ) Severe Diarrhea

( ) Dumping Syndrome ( ) J-Tube used for feeding ( ) Blood glucose fluctuations ( ) Circulatory overload.

Nursing Agency or Private Care: ( ) Yes ( ) No _____________________________ Interested in being contacted by nursing? ( ) Yes ( ) No

Name of Agency