SHEPHERD
Home Health & Hospice, LLC

REFERRAL INTAKE FORM

PLEASE FAX THE COMPLETED FORM (580)323-2581 OR CALL US AT (580)323-1580

REQUIRED PATIENT INFORMATION: **REFERRAL DATE:**_____

PATIENT'S FULL NAME: _____

DATE OF BIRTH: _____ SOCIAL SECURITY #:_____

CONTACT PERSON:_____ CONTACT NUMBER: _____

PLACE OF SERVICE: HOME ☐ OTHER ☐ ADDRESS: _____

PRIMARY DIAGNOSIS: _____

INSURANCE (LIST OR ATTACH FACESHEET): ☐ MEDICARE ☐ MEDICAID ☐ OTHER:

REFERRAL INFORMATION:

☐ **HOME HEALTH**

- ☐ NURSE TO EVAL AND ASSESS
- ☐ PHYSICIAL THERAPY
- ☐ SPEECH THERAPY
- ☐ OCCUPATIONAL THERAPY
- ☐ WOUND CARE/WOUND VAC
- ☐ PICCLINE OR PORT CARE
- ☐ INFUSION SERVICES
- ☐ DISEASE MANAGEMENT
- ☐ OTHER: _____

☐ **HOSPICE**

TERMINAL ILLNESS: _____

TRANSPORT: ☐ PRIVATE VEHICLE ☐ EMS

☐ **HOME MEDICAL EQUIPMENT**

HEIGHT: _____ WEIGHT: _____

- ☐ WHEEL CHAIR
- ☐ HOSPITAL BED
- ☐ OXYGEN
- OXYGEN SATURATION: _____
- OXYGEN TEST DATE: _____
- ☐ OTHER: _____

ADDITIONAL ORDERS OR SPECIAL INSTRUCTIONS: _____

REFERRAL CONTACT INFORMATION:

REFERRAL NAME:_____ PHONE:_____ FAX:_____

REFERRAL PHYSICIAN INFORMATION:

REFERRING DOCTOR NAME:_____ PHONE:_____

THANK YOU FOR CHOOSING SHEPHERD HOME HEALTH AND HOSPICE

PHONE: 580.323.1580 FAX: 580.323.2581