Our Lady of Peace
HOSPICE & HOME HEALTH CARE

OLP Hospice & Home Health Care
Referral Form

FAX: 651-789-0078 **Phone: 651-789-5030**

Copy of FACE sheet
If DNR/DNI - include copy

Copy of current H&P
Copy of Health Care Directive if applicable

If you don't have access to DNR & HCD, let family know we will need a copy

Date _____ **Time** _____ **Hospice** _____ **Home Health Care** _____

Name: _____

Address: _____

Phone: _____ **DOB** _____ **Age** _____

Referral Source (Name/Phone/Email) _____

Advertisement

KS95	**Newspaper**	**Social Media**	**Other**

Emergency Contact (Name/Number) _____

Medicare# _____ **Medicaid #** _____ **SSN** _____

Other insurance _____ **Policy #** _____

Primary Doctor _____ **Phone** _____

Diagnosis _____

Pertinent Health History

_____

_____

Palliative Care Appropriate? If yes, describe _____

_____

Specific Services/Care Needs _____
SN _____**HHA** _____ **PT/OT/ST** _____ **SW** _____ **Alternative Therapies** _____

Wound? Yes / No Type: _____ **Acquired where?** _____
Location: _____ **Stage:** _____

Alert & Oriented? ☐ / ☐ **DNR/DNI?** ☐ / ☐ **(if yes, include copy)**

Patient/Family/caregiver agreeable to care? ☐ / ☐

Behavioral Concerns? ☐ / ☐ **If yes, describe:** _____