Our Lady of Peace
HOSPICE & HOME HEALTH CARE

OLP Hospice & Home Health Care
Referral Form

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

Date: _____ **Time:** _____

Admission for (mark one): **Home Health Care** _____ **Hospice** _____

Your Name: _____
Company: _____
Phone: _____
Email: _____

Please include the following information

- ❑ Signed orders by a physician (for hospice or home health care)
- ❑ FACE Sheet
- ❑ Current H&P
- ❑ DNR/DNI if available
- ❑ Health Care Directive if applicable
  - ❑ If you don't have access to DNR & HCD, let the family know we will need a copy
- ❑ Completed the following 2 pages

The total number of pages in fax:

Name: _____

Address:_____

Phone: _____

DOB _____ Age _____

Emergency Contact (Name/Number) _____

Medicare# _____ Medicaid # _____
SSN _____

Other insurance _____
Policy # _____

Primary Doctor _____
Phone _____

Diagnosis_____
_____
_____

Pertinent Health History
_____
_____
_____
_____

Is 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? Yes ___ No ___ DNR/DNI? Yes ___ No ____ (if yes, include copy)

Patient/Family/caregiver agreeable to care? Yes ___ No ___

Behavioral Concerns? Yes ___ No ___
If yes, describe: _____
_____
_____

How did you hear about OLP Hospice & Home Health Care

Advertisement
MPR _____ Newspaper _____ Social Media _____ Rep _____
Word of Mouth _____
Previous Experience _____
Education event _____