Transitions® HomeHealth

REFERRAL

Transitions® PalliativeCare

Referral Fax 919-828-9514

Date: _____

Phone: 919-828-0890 (Ask for Access Department)

Number of Pages to follow: _____

FAX IN:

- ☐ This sheet signed by physician
- ☐ H&P / FL2 / Hospital discharge summary
- ☐ Demographic Sheet / Face Sheet (include DOB, SS#, insurance information, responsible party)
- ☐ Office visit notes within the last 90 days
- ☐ ICD-10 codes

Name of person completing this referral: _____

Patient: _____ Primary Diagnosis: _____

Physician (print): _____

*Signature required below

Physician Telephone: _____ Physician Fax: _____

☐ Order for Consultation for **Transitions PalliativeCare**

Please check all boxes that apply.

- ☐ Symptom management
- ☐ Determine goals of care for patient and family
- ☐ Advance care planning/decision making
- ☐ Patient and family support

Describe reason for referral to Transitions PalliativeCare:

_____

_____

_____

Do you want recommendations only

☐ Yes ☐ No

Do you want recommendations and have the Transitions PalliativeCare provider write orders?

☐ Yes ☐ No

What is the best way to communicate findings of the consult:

☐ phone number _____

☐ fax number _____

☐ Order for **Transitions HomeHealth** for

- ☐ Nurse evaluation
- ☐ Home Health Aide
- ☐ PT evaluation & treatment
- ☐ OT evaluation & treatment
- ☐ SLP evaluation & treatment

☐ Social Worker

MD order is needed for HomeHealth (Medicare COP §484.18) Medicare will not accept orders from PAs or NPs for Home Health services.

*Physician Signature:

_____

Signature required

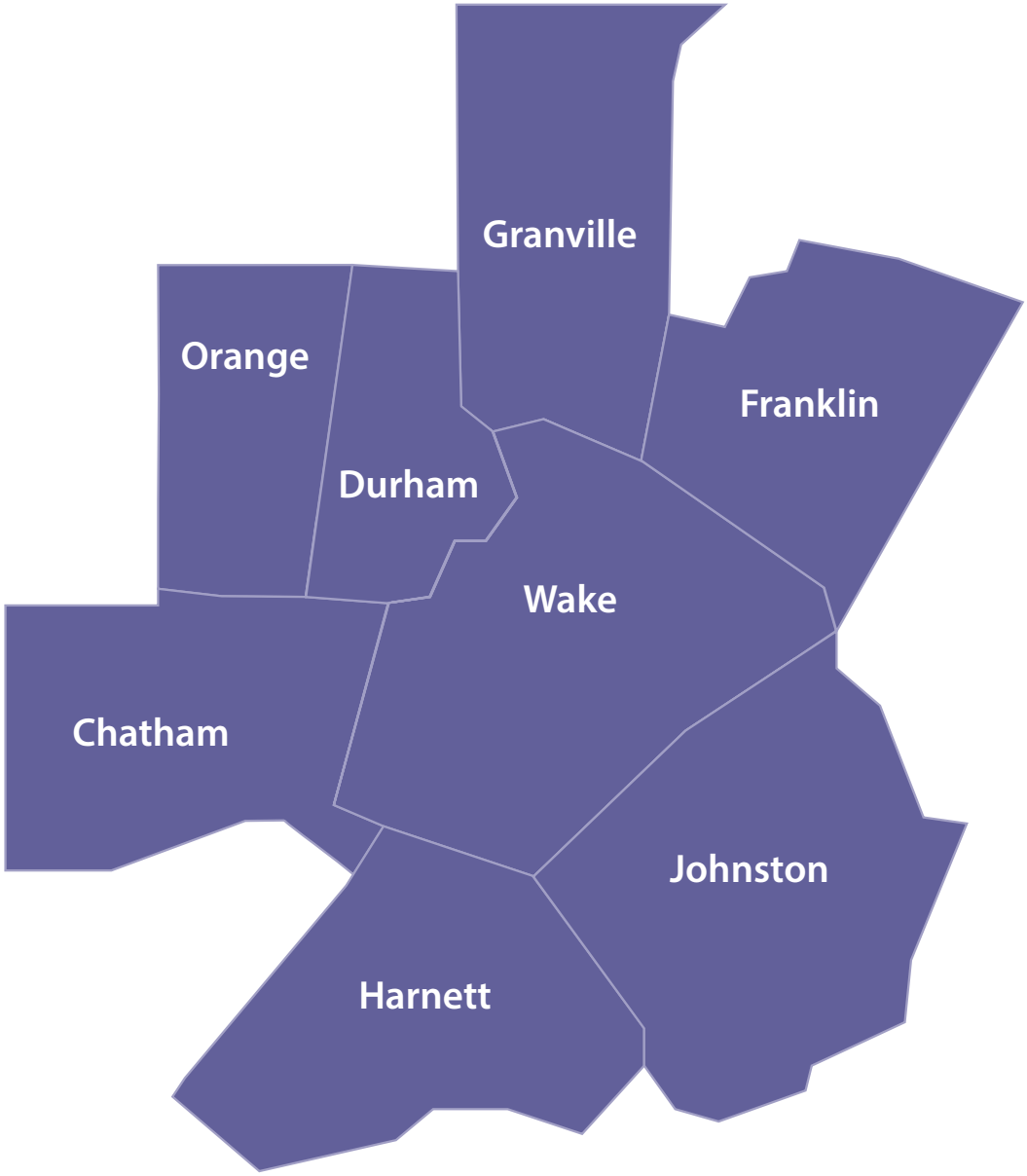
_____

Date

No stamped signatures or dates.

8/19

Coverage Area For Care



Transitions® LifeCare

919.828.0890
Referral Fax: 919.828.9514

transitionslifecare.org