**INTERFACILITY REFERRAL FORM FOR CAREMUST**

* **HOME HEALTH (CLINIC, BOARD & CARE and INDEPENDENT LIVING)**
* **HOSPICE**

 **Date Of Referral:\_\_\_\_\_\_\_\_\_**

**TO: CAREMUST HOMEHEALTH/HOSPICE** **FROM: FACILITY\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **7013 REALM DR.SAN JOSE, CA 95119 Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Tel.408-755-1216 Fax.408-663-523 Tel.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PATIENTS INFORMATION**

|  |  |  |
| --- | --- | --- |
| **Patient:** | **SS ID Verify** | **Date Of Birth** |
| **Address:** | **Medicare:#** | **Age/Sex/Race** |
| **Phone:** | **Medical:#** | **Other Insurance** |

**REFERRING PHYSICIAN:**

|  |  |
| --- | --- |
| **Name Of Physician** | **Name of Marketer/Tel** |
| **UPIN/NPI#** | **Phone/Fax** |
| **PRIMARY DIAGNOSIS** | **Please attach:*** **Face-to-Face (signed by MD)**
* **HPI, Progress Notes**
* **Medication List**
* **Pharmacy Info**
 |
| **Change of Condition for Home Health** | **Justification for Hospice Care** |

**OFFICE/INTAKE PROCESS:**

|  |  |
| --- | --- |
| **Eligibility check, print copy and attach? YES No****Check by:** | **Approve Admission by:** |
| **Print and attach Eligibility \_\_\_\_YES \_\_\_\_\_NO** | **Date of SOC:** |

**Medication List:**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **HSCC Pay** | **Discontinue** | **Medication** | **Strength** | **Dose** | **Frequency** | **Indication** | **Route** | **Quantity** |
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