PHONE: 866-323-5974
FAX: 866-296-1545

McLaren Visiting Nurse & Hospice
REFERRAL FORM

❑ **Certified** ❑ **Infusion** ❑ **DME**
❑ **Hospice** ❑ **HCP**

Ordered Services:
❑ Dietitian ❑ Inpatient ❑ SN ❑ HHA ❑MSW ❑ HCP ❑ Hospice ❑ Brian's House
❑ Other ____

Patient: Last Name	First Name	MI	SS#: / MR#:	Home Phone:

Address for Care:

City: Zip:

Referral Source:

Referring Person:

Phone:

Complete Birthdate: ____________ Age: ________ Sex: ❑ M ❑ F
Marital Status: ❑ S ❑ M ❑ W ❑ D ❑ Sep

Dischg Date:__________ **SOC Date:** __________
Referral Date: ____________________________
Hospital Admit: ____________________________
Rehab Admit: ____________________________

Patient's Address (If not the same as above.)

Contact Person:
Name:
Relationship:

Home: ________________
Work: ________________
Cell: ________________

SS #: ____________________________
Primary Ins.: ____________________________
Policy #: ____________________________
Group #: ____________________________
Secondary Ins.#:____________________________
Policy #: ____________________________
Group #: ____________________________

Allergies:

Diagnosis:

❑ Caucasian
❑ Hispanic ❑ Asian
❑ African American ❑ Other: _________

Chief Complaint:

Communicable Disease ❑ Y ❑ N
If yes explain: _______________

Diet: (specify)

Surgery/Procedure:

MEDICAL ORDERS/PLAN OF TREATMENT:

Wound Orders:

Caregiver to assist (wound orders)

INFUSION / ENTERAL ORDERS:
Ordering Physician: ________________________________
Caregiver to assist: ________________________________
I.V. Access: ____
PICC Insertion Date: _______________________________
Lumen Size: __________________ Length: ______________

Company: ________________________Phone:_____________

Dosing:

Medical History:

X-ray Results:

Vital Signs:

Temperature: ___________ Pulse _________ Respirations: __________ B/P: __________

Height: ____________ Weight: _________

Mental State: ❑ Alert ❑ Depressed ❑ Lethargic ❑ Disoriented ❑ Confused ❑ Other _______________

In-Hospital Teaching

❑ Colostomy Care ❑ Enteral Feedings

❑ Insulin Administration ❑ IV Infusion

❑ Wound Care ❑ Tube/Drain Care

❑ Tracheostomy ❑ Injections

Labs Ordered:

Results: ____

Ordering Phy.:_______________ **Fax #:**_________________

Therapy: ❑ Physical Therapy ❑ Occupational Therapy ❑ Speech Therapy ❑ Maximum Mobility

Activities of Daily Living:

❑ Dressing ❑ Eating ❑ Bathing ❑ Independent ❑ Assisted Min Mod Max Unable: What? ___________

Activity Limitations:

❑ Ambulatory ❑ Ambulatory with assist: Min Mod Max Unable: What? ___________ Device: What? ___________

Weight Bearing Status: ___________________________ Extremity involved: __________________

Mobility: (circle one)

Transfers: Min Mod Max

Bed Mobility: Min Mod Max

Confined:

❑ Bed ❑ Chair

DME Equipment Orders: Company:____

Phone:__________________ Vended: ____________________

Equipment: (please circle) Hospital Bed Side Rails Trapeze APP Mattress BSC Walker Cane Wheelchair CPM

Oxygen: ___LPM ❑ Continuous ❑ Activity ❑ Sleep ❑ Qualifying values________________ Other: _________________

Wound Clinic: M T W Th F **Chemotherapy:** M T W Th F **Radiation:** M T W Th F

(Please circle)

Telehealth Appropriate: ❑ Y ❑ N **Lifeline Appropriate:** ❑ Y ❑ N

Advance Directives: ❑ Y ❑ N

Referring Physician: ____ Phone: _________________ Fax: __________

PCP: ____ Phone: _________________ Fax: ___________

485 Physician Signature: _____________________________________ Phone:_________________ Fax: ___________

Certifying Hospice Physician: __________________________________ Phone: _________________ Fax: ___________

Physician to manage Hospice Care: ______________________________ Phone: _________________ Fax: ___________

Order Taken By: ____ Date: ___________________