



PATIENT INTAKE & REFERRAL

HOSPICE | HOME HEALTH

PATIENT, INSURANCE & REFERRAL INFORMATION

SERVICE REQUESTED

☐ Hospice ☐ Home Health ☐ Both / Evaluation Needed ☐ Urgent

REFERRAL DATE

REQUESTED START OF CARE

DIVERGENT ND LIAISON

INTAKE / TRACKING ID

PATIENT INFORMATION

LAST NAME

FIRST NAME

DATE OF BIRTH

SOCIAL SECURITY NUMBER

MIDDLE

PHONE

EMAIL

PREFERRED LANGUAGE

STREET ADDRESS

CITY

STATE

ZIP CODE

CURRENT LOCATION / FACILITY

ROOM / UNIT

MRN

PRIMARY CONTACT / DECISION MAKER

NAME

RELATIONSHIP

PHONE

EMAIL

LEGAL AUTHORITY, IF ANY (POA / GUARDIAN)

INSURANCE

PRIMARY PLAN

MEMBER ID

GROUP / PLAN NO.

SECONDARY PLAN

MEMBER ID

MEDICARE / MEDICAID ID

REFERRAL SOURCE & PROVIDERS

REFERRING ORGANIZATION / PERSON

PHONE

FAX

PCP / FOLLOWING PROVIDER

PHONE

FAX



PATIENT INTAKE & REFERRAL

HOSPICE | HOME HEALTH

CLINICAL, FUNCTIONAL & SERVICE NEEDS

CLINICAL OVERVIEW

PRIMARY DIAGNOSIS / ICD-10

DATE DIAGNOSED

SECONDARY DIAGNOSES / COMORBIDITIES

ALLERGIES / REACTIONS

PREFERRED PHARMACY / PHONE

RECENT HOSPITALIZATION / ER VISIT / DISCHARGE DATE

HOSPICE INFORMATION

☐ Terminal diagnosis documented

☐ Prognosis of 6 months or less noted

☐ Prior hospice

PATIENT / FAMILY GOALS, DECLINE OR ELIGIBILITY INDICATORS

☐ Full Code

☐ DNR

☐ POLST / Advance Directive available

☐ Agency preference discussed

HOME HEALTH INFORMATION

☐ Skilled Nursing

☐ Physical Therapy

☐ Occupational Therapy

☐ Speech Therapy

☐ Social Work

☐ Home Health Aide

☐ Wound Care

☐ Other

FACE-TO-FACE DATE, IF COMPLETED

HOMEBOUND REASON / SKILLED NEED

FUNCTIONAL STATUS & SAFETY

☐ Independent

☐ Cane

☐ Walker

☐ Wheelchair

☐ Bedbound

☐ Fall Risk

☐ Oxygen

☐ Wound(s)

☐ DME needed

☐ Caregiver available

☐ Interpreter

ADL ASSISTANCE, EQUIPMENT, SAFETY CONCERNS OR OTHER NEEDS

REFERRAL SUBMITTED BY

NAME / TITLE

PHONE

DATE / TIME



PATIENT INTAKE & REFERRAL

HOSPICE | HOME HEALTH

SYMPTOMS, DOCUMENTS & AUTHORIZATION

CURRENT SYMPTOMS / CONCERNS

- | | | |
|---|--|---|
| ☐ Pain | ☐ Shortness of breath | ☐ Weakness / fatigue |
| ☐ Confusion | ☐ Weight loss / poor intake | ☐ Falls |
| ☐ Nausea / vomiting | ☐ Anxiety / agitation | ☐ Wound / skin issue |
| ☐ Medication concern | ☐ Caregiver stress / grief | ☐ Other |

DETAILS, SEVERITY, ONSET AND RECENT CHANGES

DOCUMENTS INCLUDED

- | | | |
|--|--|--|
| ☐ Face sheet / demographics | ☐ Signed order / referral | ☐ H&P / recent clinical note |
| ☐ Medication list | ☐ Discharge summary | ☐ Insurance cards / eligibility |
| ☐ Labs / imaging | ☐ POLST / advance directive | ☐ Face-to-face documentation |

MISSING / REQUESTED DOCUMENTS

CONTACT PERMISSION & PATIENT PREFERENCE

- ☐ May call ☐ May leave voicemail ☐ May text ☐ May email ☐ No agency preference stated

BEST CONTACT / TIME

PATIENT / FAMILY AGENCY PREFERENCE, IF ANY

AUTHORIZATION TO COORDINATE REFERRAL

I authorize Divergent ND to contact me or my representative and to share the information in this referral with selected hospice or home health providers for the purpose of coordinating an evaluation and services. I understand that this intake does not guarantee eligibility, does not replace a provider's admission consent, and is not an emergency service.

PATIENT / AUTHORIZED REPRESENTATIVE NAME

RELATIONSHIP

SIGNATURE

DATE

TIME

For emergencies or immediate medical danger, call 911. Send protected health information only through an approved secure method.