MERCYONE℠

Des Moines Home Care and Hospice

EXPRESS REFERRAL FORM

ALERT Your patient's admittance into our care will be delayed if fields are left incomplete or required forms are not attached.

Referral required information

Complete this form, gather required documentation and fax to:

515-643-0975

Thank you for your partnership in ensuring swift patient care.

Name _____ Date _____

Company _____

Phone _____ Fax _____

Email address if available _____

Required documentation

Please attach:

- ☐ Demographic sheet, including insurance information
- ☐ H & P (including secondary diagnoses/comorbidities)
- ☐ Physician signature (on this form or on attached physician order)
- ☐ Progress notes
- ☐ Current medication list

Also required for referrals from skilled nursing facilities

- ☐ Admission/Anticipated Discharge Dates
- ☐ Facility Discharge Summary

COMPLETE THE FOLLOWING FIELDS ONLY IF THE INFORMATION DOES NOT ALREADY APPEAR IN THE ATTACHED DOCUMENTATION.

Patient information

Patient's name _____

D.O.B. _____ Phone _____

Email address if available _____

Has the patient been discharged from a facility in the last 14 days? ☐Y ☐N

Facility name _____ Dates _____

Physician to Follow in the Community
(First & last Nname required, address & telephone number if available)

_____

Services requested

◯ **Hospice** ◯ **Palliative care**

◯ **Home care**

☐ Nursing ☐ PT ☐ OT ☐ Speechlanguage pathology

☐ Social work ☐ Wound care ☐ Infusion ☐ Home health aide

Ordered by
(Physician, NP or PA):

Printed name

_____

Signature

_____

Date

_____

Or:
Verbal order from

_____

Obtained by (printed name)

_____

Signature

_____

Date

_____