Continuum
Home Health & Hospice

REFERRAL FORM

CENTRAL INTAKE ~ **ALL Eastern NC Referrals** *See back for service area	**Fax: 910-989-2691** ~ **Call: 910-989-2682**	During normal business hours, you should hear from us within **30 minutes or less**. If not, we ask for a brief call to ensure receipt.

Patient Name: _____ DOB: _____

Phone: _____ Date of Last Physician Visit: _____

Attending Physician/PCP: _____ Phone: _____

Primary Insurance & Number: _____

Primary Diagnosis Associated with Referral: _____

Referral Provider Name: _____ Referral Provider Number: _____

Attach Demographics Sheet and H/P, DC Summaries as Appropriate

Evaluate for service eligibility: ☐ Home Health ☐ Hospice ☐ Unsure

Specific Home Health Services if known: ☐ Nursing ☐ PT ☐ OT ☐ ST

Disease Management Programs if indicated: ☐ CHF ☐ DM ☐ COPD ☐ Wound ☐ CVA ☐ Arthritis

ADDITIONAL INFORMATION:

_____

_____

_____

_____

FOR PHYSICIAN USE ONLY

Physician Order:
Please evaluate for the above services and programs.

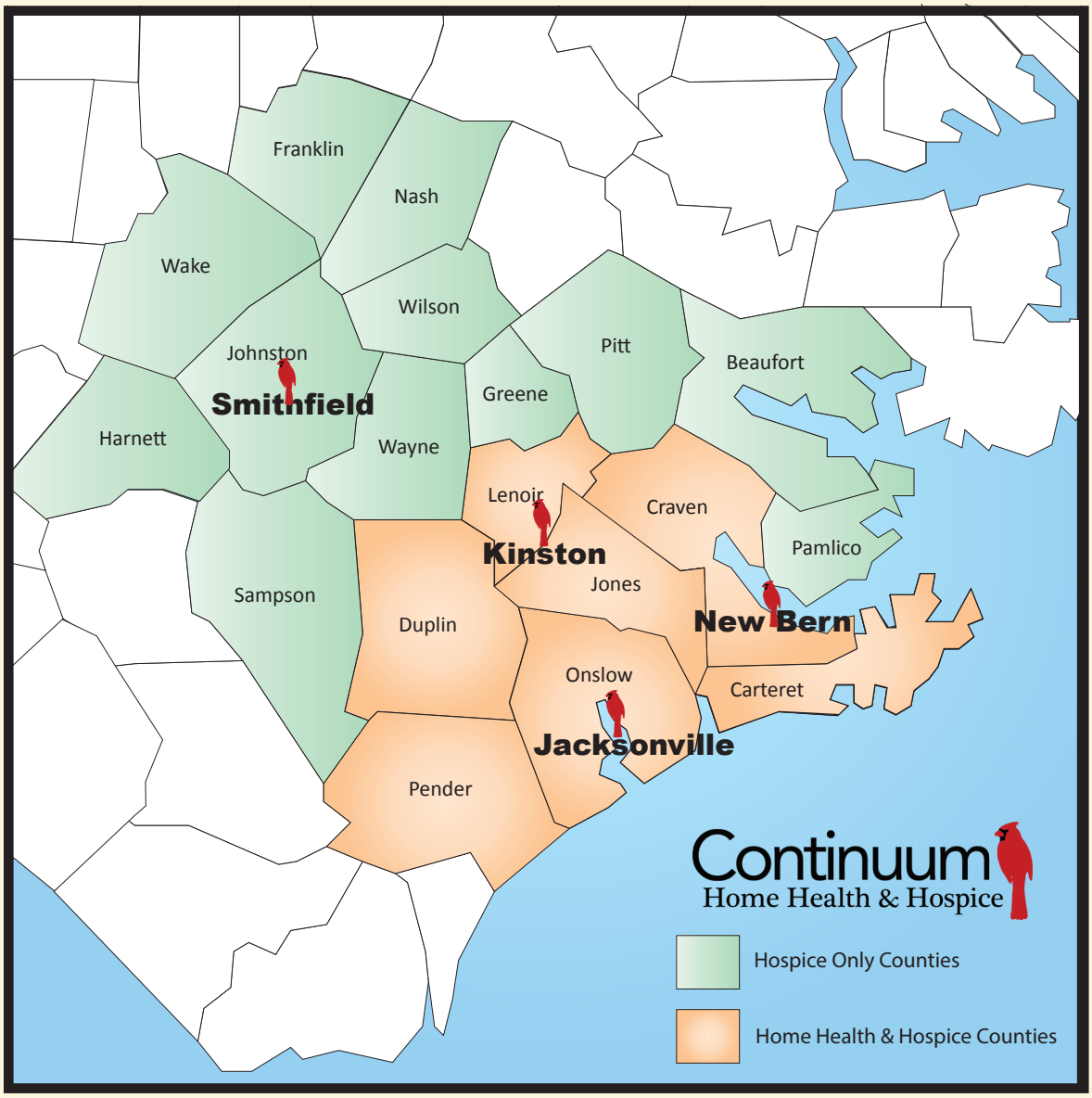
Additional Orders: _____

_____

_____

Physician Name: _____ Date: _____

Physician Signature: _____



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