Hospice of Union County
"A Special Kind of Caring"

700 W. Roosevelt Blvd.
Monroe, NC, 28110
FAX: 704-292-2190

REFERRAL INTAKE FORM

Date: ____________________ Referral Source: ____________________

Relationship to Patient: (if applicable) : ____________________

How did you learn about Hospice of Union County? ____________________

PATIENT INFORMATION

(Mr./Mrs./Ms) ____________________ Sex: __________ Race: __________

Marital Status : ____________________ Date of Birth: __________ SS#: ____________________

Address: ____________________City: ____________________

County: ____________________ State: __ __ Zip: __________ Phone: ____________________

Primary Care Physician (Current Physician): ____________________

Address: ____________________

City: ____________________ State: __ __ Zip: __________ Phone: ____________________

Other Physicians: ☐ Specialist ☐ Consultant ☐ Family Physician

Name: ____________________

Address: ____________________

City: ____________________ State: __ __ Zip: __________ Phone: ____________________

Hospice Diagnosis: ____________________

Other Diagnosis: ____________________

INSURANCE INFORMATION

Medicare #: ____________________ Medicaid #: ____________________

Insurance Co.: ____________________ ID / Group #: ____________________

Address: ____________________

City: ____________________ State: __ __ Zip: __________ Phone: ____________________

CAREGIVER/RESOURCE INFORMATION

Name: ____________________Relationship: ____________________

Address: ____________________City: ____________________

State: __ __ Zip: __________ Phone (W): ____________________ Phone (H): ____________________

OTHER CONTACT PERSON

Name: ______________________________ Relationship: ______________________

Address: ______________________________ City: ______________________

State: __ __ Zip: ____________ Phone (W): ______________ Phone (H): ______________

PHARMACY CONTACT

Name: ______________________________ Phone: ______________________

MEDICAL EQUIPMENT CONTACT

Name: ______________________________ Phone: ______________________

OTHER PERTINENT INFORMATION

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DETERMINATION OF IMMEDIATE NEEDS

Condition of Patient - Describe: ______________________________

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Current Location of Patient: ☐ Home ☐ Nursing Home ☐ Other

Name of Facility: ______________________________ Room # ______________

Address: ____

City: ______________ State: __ __ Zip: ____________ Phone: ______________

Does Patient Live Alone? __________ Explain: ______________________

Emergency Contact Person ______________________________ Phone: ______________

Emotional Status: ☐ No Known Problem ☐ Depressed ☐ Withdrawn ☐ Accepting

Awareness of Diagnosis: Patient: Yes No Explain ______________________
Family: Yes No Explain ______________________

Awareness of Prognosis: Patient: Yes No Explain ______________________
Family: Yes No Explain ______________________

Activities of Daily Living: ☐ Ambulatory ☐ Bedbound ☐ Wheelchair ☐ Walker ☐ Other

Needs Assistance With: ☐ Feeding ☐ Ambulation ☐ Personal Hygiene ☐ Other

Needs the Following Medical Equipment:

☐ Hospital Bed ☐ Overbed Table ☐ Walker ☐ BSC ☐ Wheelchair ☐ Lifeline

Allergies: ____

Diet: ____

OTHER INFORMATION

☐ Intravenous Line Name of IV Fluids: ____________________

☐ Ports Type: ____________________

☐ Foley Catheter Last Changed: ____________________

☐ Gastrostomy/Feeding Tube Type: ☐ PEG ☐ Nasogastric ☐ Other: ____________________

☐ Patient Is Receiving Tube Feedings Name of Feeding: ____________________

By: ☐ Bolus ☐ Continuous Feeding ☐ Schedule: ____________________

☐ Colostomy

☐ Urostomy

☐ Patient Is On Pain Pump Name of Pain Medication: ____________________

☐ Patient Is Receiving Oxygen at: ____________________ liters/minute through

Oxygen Type Needed: ☐ Liquid ☐ Concentrator

Patient is Currently Undergoing/Has Recently Undergone

☐ Chemotherapy for: ☐ Palliation ☐ Cure Frequency: __________ Treatment Length: __________

☐ Blood Transfusion for: __________ Frequency: __________ Treatment Length: __________

☐ Radiation Therapy for: ☐ Palliation ☐ Cure Frequency: __________ Treatment Length: __________

☐ Other ____________________

Directions to Home:

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☐ High Risk - Implement Precautions ☐ Other ____________________

Signature: ____________________ Date: ____________________