Dartmouth Health

Visiting Nurse and Hospice for Vermont and New Hampshire

Home Health & Hospice Referral Form

Fax completed form to 603-640-6851

Patient Information | Demographics

Patient's Name: _____ D.O.B. _____ Phone: _____

Patient's Physical Address (no PO Box): _____

Patient's Mailing Address: _____

Date and location of last hospitalization or post-acute facility (if any): _____

Emergency Contact: _____ Phone: _____

Referring Facility: _____ Referring Provider: _____

Physician who will sign Care Plan and Orders: _____ Phone: _____

Referral Date: _____ Start of Care Request Date:

Insurance information: _____

Diagnosis or Medical Condition

List the diagnosis or medical conditions that are the primary reason the patient requires home care.

Home Health Skilled Services (Check and describe all services that apply to this patient):

- ☐ Skilled nursing for: _____
- ☐ Home Health Aide for: _____
- ☐ Physical Therapy for: _____
- ☐ Occ. Therapy for: _____
- ☐ Speech Therapy for: _____

Other Services (Check and describe all services that apply to this patient):

- ☐ Maternal Child Health for: _____
- ☐ Hospice Care for: _____

Additional Documentation to include:

- ☐ History & Physical
- ☐ Demographics
- ☐ Discharge Summary
- ☐ Medication List

The patient is under my care and I have initiated the establishment of the plan of care for home health.

Referring Provider Printed Name: _____

Provider Signature _____ **Date | Time** _____

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