FAX REFERRAL FORM

INTAKE FAX: 952-898-4006 **MAIN OFFICE PHONE: 952-898-1022**

EMERGENCY ADMISSION: PLEASE CALL MAIN OFFICE DIRECTLY

Date: _____ Facility: _____

Referred by Name / Title: _____

Facility Phone: _____ Facility Fax: _____

Patient Name: _____ DOB:_____

Social Security Number: _____ Medicare Number:_____

Attending Provider:_____

Hospice Indicators—If your resident exhibits one or more of these symptoms, they may qualify for Minnesota Hospice care. Please check all that apply.

- ☐ Frequent hospitalizations or ER visits
- ☐ Recent or progressive weight loss/gain
- ☐ Decreased appetite
- ☐ Requires more assistance with ADL's
- ☐ Increased incontinence
- ☐ Decubitus ulcers / increased wounds / wounds not healing properly
- ☐ Decline in mental status / increased disorientation / confusion
- ☐ Change in communication—verbal to nonverbal
- ☐ Recurrent infections
- ☐ Behavioral changes
- ☐ No longer making progress PT / OT / SP
- ☐ Frequent falls
- ☐ Pain requiring transition from OTC medication to opioid medication
- ☐ Difficulty swallowing / pocketing of food
- ☐ Increased shortness of breath
- ☐ Decreased stamina (excessive sleep / increased fatigue)
- ☐ Increased edema

Please check **one** of the following:

- ☐ Please send a Minnesota Hospice representative to collect necessary information
  or
- ☐ This referral fax includes physician order, face sheet, H&P, med list, POA paperwork and any other relevant information available