Lake Sunapee Region
VNA & HOSPICE

PATIENT REFERRAL FORM

Patient Name:_____ **DOB:**_____

Physical Address (Please No PO Box):_____

Phone to Reach Patient:_____ **Alternate/Backup phone:**_____

Discharging Facility:_____

Primary Diagnoses:_____

Additional Information:_____

Primary Care MD/Homecare Attending:_____

Phone:_____

Requested Services

☐ **Home Care:** ☐ **RN** ☐ **PT** ☐ **ST** ☐ **OT** ☐ **SW** ☐ **HHA** ☐ **Telemedicine**

- ☐ **Pediatric Care:** ☐ **Mother** ☐ **Baby** ☐ **Pediatric**
- ☐ **Wound Care**
- ☐ **IV Therapy**
- ☐ **PT/INR Due:**_____ **Call Results to:**_____

☐ **Hospice**

Please Fax the Following: (needed to complete the referral)

- ☐ **Patient Demographics**
- ☐ **Medication List**
- ☐ **Discharge Summary and Visit Note (as available)**
- ☐ **Signed MD orders**
- ☐ **Face to Face Form (Medicare or Medicare Advantage Only)**

FAX #: 603-526-4272

Revised 8/19/15