

10/5/2007 4:17:25 PM

SILVERADO HOSPICE, INC.
REFERRAL/ INTAKE / FACESHEET

Patient #:	_____	Admit Date:	_____	Time:	_____	Discharge Date & Time:	_____
Patient Name:	_____	Age:	_____	Martial Status:	_____		
Street Address:	_____	DOB:	_____	Ethnic:	_____		
City/State/Zip:	_____	Male	Female				
Location:	_____	Telephone #:	_____	Fax#:	_____		

REFERRAL INFORMATION

Referral Source:	_____	Title:	_____	Telephone#:	_____
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Referral Request: N/A

PROGRAM/INSURANCE INFORMATION:

Program:	Orange County	San Diego County
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SS#	_____	Medicare:	_____	EFF Date A:	_____	EFF Date B:	_____
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Medical #:	_____	Effective Date:	_____	Benefit Period:	1 st 90 / 2 nd 90 / 3 rd 60
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Insurance Name/Type:	_____	ID#:	_____
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RESPONSIBLE INFORMATION

Primary Caregiver Name:	_____	Relationship:	_____
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Address (Street/City/State/Zip):	_____
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Home Telephone #:	_____	Cell #:	_____
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Other Caregivers: _____

ATTENDING PHYSICIAN:

Physician's Name:	_____	Telephone #:	_____	Fax #:	_____
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Hospice Physician: _____

DIAGNOSIS/ALLERGIES

Hospice DX:	_____	ICD-9 Code:	_____
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Co-Morbidities: _____

REASON NOT ADMITTED

Referral received by: Mirella Villegas

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