ALL SEASON'S HEALTHCARE, INC.
16660 Paramount Blvd. Suite 107 Paramount, CA 90723
Tel. 562-924-9618 • Fax: 562-478-4535 • Referral FAX 562-478-4536

REFERRAL/ INTAKE FORM

Referral Source:					**Phone:**	
Date:					**Time:**	
Referral Taken By:						
PATIENT INFORMATION						
Last Name:		**First:**		**Initial:**		**Nickname:**
Address:						
City:			**State**	**Zip Code:**		
Phone:	**Age:**	**DOB:**	**Marital Status:** M S W	**# of children:**	**Sex:** Male Female	
Primary contact:			**Relationship:**		**Phone:**	
Other contact:			**Relationship:**		**Phone:**	
Ordering Physician:					**Phone:**	
Primary Hospice MD:					**Phone:**	
Hospital/ SNF	**Room #:**			**Admit Date:**	**Discharge Date:**	
Case Manager Name/Phone/Extension:						
Primary hospice Diagnosis:						
Other Pertinent Diagnoses:						
Getting Active Treatment: ____ Yes _____No			**Pt. Aware of Diagnosis: _____Yes _____No**			
Allergies:	**Ht:**	**Wt.**	**Vital Signs:**			
Respiratory precautions? ____ Yes ____No						
H & P Requested? ____Yes ____No						
Primary Payor: Medicare Medi-Cal Private Insurance HMO/Managed Care Other:______________						
SS#:						
Medicare #:						
Medicaid #:						
PVT Insurance Co:		**Policy #:**		**Group #:**		
Subscriber Name:						

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<table>
<tr><th>Date/Time and Initial When Completed</th><th colspan="2">Item / Task</th></tr>
<tr><td></td><td>Patient Documents Faxed: (to be done by Community Liasion)</td><td>___ History and Physical (latest)
___ Laboratory Results (last 5 days or latest)
___ Progress Notes (indicating hospice diagnosis)
___ Medication List (latest)
___ Physician Order for Hospice</td></tr>
<tr><td></td><td>Patient Documents Received: (to be done by Intake/Office)</td><td>___ History and Physical (latest)
___ Laboratory Results (last 5 days or latest)
___ Progress Notes (indicating hospice diagnosis)
___ Medication List (latest)
___ Physician Order for Hospice</td></tr>
<tr><td></td><td colspan="2">Call Pt. To Schedule Intake Date/Time Called:___________ Spoke with: __________________
Date scheduled:________ By:____________</td></tr>
<tr><td></td><td colspan="2">Input Referral into Careanyware</td></tr>
<tr><td></td><td colspan="2">Verify Insurance Eligibility: Add Communication Note under "Billing"</td></tr>
<tr><td></td><td colspan="2">Scan and upload Eligibility to Patient File</td></tr>
<tr><td></td><td colspan="2">Get Authorization</td></tr>
<tr><td></td><td colspan="2">Input auth into Careanyware</td></tr>
<tr><td></td><td colspan="2">Director of Patient Care Services (DPCS) Notified of admission</td></tr>
<tr><td></td><td colspan="2">MSW Notified of admission</td></tr>
<tr><td></td><td colspan="2">Chaplain Notified of Admission</td></tr>
<tr><td></td><td colspan="2">NURSING:</td></tr>
<tr><td></td><td colspan="2">DME ordered</td></tr>
<tr><td></td><td colspan="2">Comfort Pak Ordered</td></tr>
<tr><td></td><td colspan="2">RN Schedule in Careanyware</td></tr>
<tr><td></td><td colspan="2">LVN Schedule in Careanyware</td></tr>
<tr><td></td><td colspan="2">CHHA Schedule in Careanyware</td></tr>
<tr><td></td><td colspan="2">MSW Schedule</td></tr>
<tr><td></td><td colspan="2">Chaplain Schedule</td></tr>
<tr><td colspan="3">Communication Notes:
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____________________</td></tr>
</table>

Administrator Signature:____ **Date:**__________________________