



Accredited by the Joint
Commission on Accreditation of
Healthcare Organizations

Health Services of the Pacific

384 Gov. Carlos Camacho Rd. Tamuning, Guam 96913

Phone: (671) 647-5355 ♦ Fax: (671) 649-0404

www.hspguam.com



Medicare Certified
Home Care Agency

Home Care & Hospice Referral Form

Patient Information:

Patient Name: _____ Phone: _____

Address of service (Home Address): _____

Mailing Address: _____

D.O.B.: _____ Age: _____ Sex: _____ Marital Status: _____

Insurances: Medicare # _____ Blue Cross/Blue Shield # _____ VA # _____
 Medicaid/MIP # _____ Netcare # _____ Aetna # _____
 Select care # _____ Tricare # _____ Other/#: _____

Primary Caregiver: _____ Phone: _____

Legal Guardian: _____ Phone: _____

Referring Diagnosis: _____

Referring Orders:

Wound Care: Orders: _____

Disease Management: CHF COPD Diabetes Cancer Other: _____

Medication Management: Anticoagulation Therapy Eight (8) or more medications

Medical Equipment Needed: Hospital Bed Wheelchair Walker Suction Machine
 Air Mattress Oxygen Cane Other: _____

Nutrition: Diet: _____ Enteral: _____ Other: _____

Elimination: Foley size: _____ Irrigate Foley Ostomy care and Education

IV Therapy: Antibiotics: _____ Medications: _____
 Line Care: (circle one) Peripheral / PICC / Central Size: _____ Insert date: _____

***Allergies:** _____

Disciplines Requested: RN PT OT HHA MSW ST RT Other: _____

Services For: Homecare services Hospice Services- *Hospice Certification signed: Y / N
 Diabetes Education (terminally ill with a prognosis of six (6) months or less)

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|---|-----------------------------|
| Name of Physician to follow and sign homecare orders: | Follow up appointment date: |
|---|-----------------------------|

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|-----------------------------------|-------|
| Signature of Referring Physician: | Date: |
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Supportive Documents:

Face Sheet Pertinent labs/x-rays/procedure reports Code Status: (circle one) Full Code / DNR/DNI
 Allergy list History & Physical Medication Lists Map to residence
 Immunization Status: *Influenza*: Y / N Date Given: _____ *Pneumovax*: Y / N Date Given: _____

Special Notes for Friday/Weekend discharge

- Please call the 24 hour on-call nurse at 647-5355 and fax required supportive documents to 649-0404.