



**HomeCare & Hospice**

家護及寧養服務

**SELF-HELP  
FOR THE  
ELDERLY**  
安老自助處

407 Sansome Street  
San Francisco, CA 94111-3123  
Tel:(415) 677-7628  
Fax:(415) 398-5903  
www.selfhelpelderly.org

**PHYSICIAN REFERRAL FORM**

Please fax to (415) 398-5903 or call Intake at (415) 677-7629.  
Once received, someone will contact you by the end of the business day  
for additional information or to confirm acceptance of this patient.

Referral for  HomeCare  Hospice

**Referring Physician:** \_\_\_\_\_ **Telephone:** \_\_\_\_\_

**Primary Care Physician** (if different): \_\_\_\_\_ **Telephone:** \_\_\_\_\_

**Patient & Insurance Information**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Telephone: \_\_\_\_\_

Address: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Gender:  Male  Female Ethnicity: \_\_\_\_\_ Language: \_\_\_\_\_

Social Security #: \_\_\_\_\_

Primary Insurance: \_\_\_\_\_ Insurance #: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_ Insurance #: \_\_\_\_\_

Acute Care Facility Admission Date: \_\_\_\_\_ Discharge Date: \_\_\_\_\_

Skilled Nursing Facility Admission Date: \_\_\_\_\_ Discharge Date: \_\_\_\_\_

**Diagnoses**

Referral Diagnosis: \_\_\_\_\_

Other Diagnoses/Co-Morbidities: \_\_\_\_\_

Recent Surgery/Procedure: \_\_\_\_\_ Date: \_\_\_\_\_

**Mental Status:**  Alert  Oriented  Forgetful  Confused  Depressed  Other\_\_\_\_\_

**Medications** at time of referral  see attached

**Services Requested:**  RN  PT  OT  ST  MSW  CHHA

**Orders:**

**Physician's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_