Resident Referral Form

This form is also available as a fillable PDF download at www.thelilyhouse.org/ResidentReferral

Submission Instructions: Please fax completed form to 508.214.0680, or email to debra@thelilyhouse.org
Also include the following:

- Clinical Notes (most recent)
- Health Care Proxy Form
- MOLST Form

We will confirm receipt of referral and follow up to discuss within 1-2 days.

Patient Name _____ **Date** _____

Agency Making the Referral

☐ Beacon Hospice ☐ Cape Cod Hospital

☐ Broad Reach Hospice ☐ Other: _____

☐ VNA Hospice

Name of Person Submitting Referral _____

Email _____ **Phone** _____

For resident eligibility, please check confirming the stateme ts below.

☐ The patient has a terminal diagnosis with a prognosis of two months or less.

☐ The patient weighs less than 250 lbs.

☐ The patient does not have a feeding tube.

☐ The patient does not require IV, IM or SQ medications.

☐ The patient does not have known active TB, COVID-19 or any other infectious disease.

☐ The patient does not require finger stick lood tests or insulin injections.

Patient Information

Name _____ **Age** _____

Home Town _____

Terminal Diagnosis _____

_____

Prognosis

☐ less than 1 week ☐ 1 week to 4 weeks ☐ 1 to 2 months

Current Living Situation

_____

_____

Current Care Giving Situation

_____

_____

Primary Care Giver

Name _____ Relationship _____

Email _____ Phone _____

Health Care Proxy

Name _____ Relationship _____

Email _____ Phone _____

Has the Health Care Proxy been invoked? ☐ Yes ☐ No

Please check all that apply.

- ☐ The patient requires wound care.
- ☐ The patient is bed-bound.
- ☐ The patient has exhibited violent or aggressive behaviors.
- ☐ The patient has dementia or Alzheimer's.
- ☐ The patient has mental health conditions.

Nutritional Intake

☐ solid foods ☐ soft/pureed foods ☐ liquids only

Any special/unique care needs?

_____

_____

_____

Reason for Referral to Lily House at this Time

_____

_____

_____

Patient's Primary Nurse _____

Email _____ Phone _____

Patient's Social Worker _____

Email _____ Phone _____