



Home Health & Hospice Care

Referral Form



800.692.4442



ReferralsSentIntake@3HC.org



866.642.5791

Referring Office/Contact Name: _____ Referring Phone #: _____

Patient Name: _____ DOB: _____

Patient Address: _____

Insurance: _____ Diagnosis: _____

Physician Signing 3HC Plan of Care: _____

SERVICES ORDERED Availability Varies By Location
<p><u>HOME HEALTH</u> - check all that apply:</p> <p> <input type="checkbox"/> Skilled Nursing <input type="checkbox"/> PT <input type="checkbox"/> OT <input type="checkbox"/> ST <input type="checkbox"/> Aide <input type="checkbox"/> SW <input type="checkbox"/> Wound Care <input type="checkbox"/> IV Medications </p>
<p><input type="checkbox"/> <u>HOSPICE</u> (Not Available in Durham, Franklin, Granville, Vance, or Warren counties)</p>

<u>Patient Information Required for Referral Processing</u>
<p>· Patient Profile · History · Physical (by MD, NP, or PA dated within 90 days of today with need for care indicated) · Medications · Primary Care Physician · Recent Facility Discharge Information (if applicable)</p>

<p><u>Comments:</u></p>
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Our Intake Care Team will contact you as soon as possible to confirm the receipt of this referral.
If you do not receive a call, please contact us at 1-800-692-4442.