LaVigne Home
for Compassionate Care

**Phone # 810-214-2852 Fax # 231-221-2547**

Date/Time of Referral_____

Referral received from_____ Contact_____

## Referral Form

Please complete and e-mail the following information to info@lavignehome.org

☐Demographic or face sheet ☐H&P ☐DPOA or guardian papers ☐DNR Order

☐Recent social work evaluation Medication list ☐Signed provider agreement if not yet complete

Name_____ DOB/Age_____

Address_____

City_____ State_____ ZIP_____

Diagnosis_____

Current Location of the patient

☐ Hospital_____Home alone_____

☐ Home with family_____Other_____

Is the patient able to make his/her own decisions? ☐ Yes ☐ No ☐ Undetermined

Primary patient representative

Name_____ Relationship_____

Contact _____

Does the patient have the following ( if yes, please send with a referral)

1) Advance Directive ☐ Yes Advocate Name_____

Relationship_____ Contact #_____ ☐ No Advance directive

2) Guardian ☐ Yes Name_____Contact #_____

☐ No Guardian

3) DNR order signed ☐ Yes ☐ No

Patient currently signed on with a Hospice Agency ☐ Yes_____ ☐ No.

If not, has the agency been selected? ☐ Yes_____

Social concerns and needs of the patient (select all that apply)

☐ Homeless ☐ No caregivers able to stay in the home

☐ Caregivers are unable to provide needed care

☐ Family has no financial means to support facility placement

☐ Patient does not qualify for Medicaid

☐ No insurance or Medicaid pending

☐ Not a US citizen

☐ Other_____

## Clinical Summary of patient

Ht _____ Wt_____

Does patient have any current, active infection(s)?

_____

Allergies_____

Does patient have a history of smoking? ☐ Yes ☐ No ☐ Unknown

Does patient have history of substance abuse? ☐ Yes ☐ No ☐ Unknown

Mental status ? ☐ Alert and oriented ☐ mild cognitive impairment ☐ confused and disoriented ☐ unresponsive

☐ Other_____

☐ Oxygen _____ Tracheostomy ☐

☐ Wound(s) _____

☐ Ambulates alone ☐ Uses device_____ ☐ Non ambulatory

Toileting: ☐ Commode ☐ Foley ☐ incontinent ☐ Colostomy or ileostomy

Nutrition: ☐ Feeds self ☐ Needs assist ☐ special diet _____

☐ Minimal to no intake ☐ supplements _____ ☐ Tube feeding

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