REFERRAL/INTAKE FORM

Phone: 800-635-7490
Fax: 989-635-4145

United Hospice Service
OF MARLETTE REGIONAL HOSPITAL

Date:	**INTAKE MANAGER:**		
FIN#	MRN#		SS#
Last Name:	First Name:		
Address:			
City:	State:	Zip:	County:
Phone#	Cell Phone#:		
DOB:	Sex:	Marital:	
Race:	Language:	Religion:	
Advise family to have copy of POA available on admission ☐			
Driver's License#			

DIAGNOSIS	
Diagnosis:	Onset:
Co-morbities:	
Allergies:	

Physician Information	
Certifying Physician:	Phone:
Address:	Fax:
Family:	Phone:
Address:	Fax:
Hospitalist:	Phone:
Address:	Fax:
Other:	Phone:
Address:	Fax:

Insurance		
MDCR ☐	BCBS ☐	
ID#	ID#:	5TH LEVEL ☐
OTHER ☐	MDCD ☐	
ID#	ID#	
Address:		
If not self …		
Insured Person Name:	Phone:	
Address:	SS#:	

Caregivers	
Name:	Relationship:
Address:	Phone:
Name:	Relationship:
Address:	Phone

ASK IF APPROPRIATE		
VETERAN ☐	Interests :	Pets:
Branch:	Hobbies:	
COVID-19 Screen: Temp___, Cough___, Dyspnea____, Sore Throat___ Exposure past 14 days____		