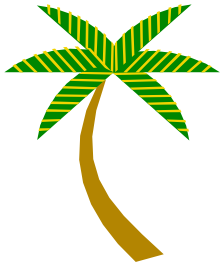

Social Work Advantage

Health Proxy Services

PATIENT REFERRAL FORM

Name of Patient: _____

Location of Patient (room/facility) _____

Name of Hospital or Hospice referring: _____

Reason for referral: (include diagnosis and admission date)

_____

_____

_____

What has been done to find family?

_____

_____

_____

What has been documented regarding patient's capacity to make health decisions?

_____

_____

Is the patient on mechanical support? _____

_____ _____

Name & **PHONE NUMBER** of person to contact Date

*Please **fax or e-mail** the completed form along with a **face sheet & call*** **(954) 547-5588 (office)**

www.Socialworkadvantage.com *(website)* ***FAX: 866-588-4312***

AHPS@Advantagehps.com *(email)* *or* **Fax: 954-756-7586 (Miami/Broward)**