HEALTH SERVICES OF THE PACIFIC

Location Address: 809 Chalan Pasaheru Unit 2, Tamuning, GU 96913
Mailing Address: P.O. Box 8838 Tamuning, GU 96931
Tel: 671.647.5355 Fax: 671.647.5358; website: www.hspguam.com

PATIENT INFORMATION

Patient Name: _____ Date of Birth _____

Marital status: ☐ S ☐ M ☐ Div ☐ Sep ☐ Wid **Gender**: ☐ M ☐ F

Residential Address: _____

Mailing Address _____

Contact Person: _____ Home #: _____ Cellphone: _____

Referring Physician: _____

Primary Care Physician
(if different from referring) _____

PHYSICIAN'S ORDERS

Referring Diagnosis: _____

Services Needed: ☐ Homecare ☐ Hospice ☐ Medical Transport ☐ Medical Equipment ☐ MedEvac ☐ Private Duty Nursing
☐ Diabetes Education ☐ Physician Home Visits ☐ Wound Care Clinic ☐ Home IV Therapy ☐ Counseling ☐ PEG/Trach Care
☐ Foley Care ☐ PICC Care ☐ Pharmacy ☐ Wound Care ☐ Other : _____

Specify Orders: _____

Covered by Insurance? ☐ Yes ☐ No **HSP Intake Dept. will obtain all necessary information*

Please check all applicable insurance(s):Please indicate **P** for **Primary** or **S** for **Secondary**

☐ Tricare (P/S) ☐ Staywell (P/S) ☐ Medicare (P/S) ☐ MIP (P/S) ☐ Calvo (P/S)
☐ Netcare (P/S) ☐ VA (P/S) ☐ Other (P/S): _____

FACE-TO-FACE ENCOUNTER

DISCIPLINE:	I certify that I have seen the patient on: _____
☐ Skilled Nursing	Clinic findings supporting the need for skilled services:
☐ Speech Language Pathology	
☐ Physical Therapy	Clinic findings supporting the patient's homebound services:

☐ I certify that this patient was seen and is under my care and that I, or a nurse practitioner or physician's assistant working with me, had a face-to-face encounter that meets the physician face-to-face requirements.

☐ I certify I am the hospital physician managing care and will sign the initial Plan of Care and continue seeing the patient as the primary physician.

☐ I certify I am the hospital physician managing care and will sign the initial Plan of Care and want all subsequent physician oversight to be managed by primary physician.

Certification of Referring Physician: _____ Date: _____
(Physician's complete name and signature)

Thank you for your referral
Please complete this referral and fax to 647-5358/649-0404

•Homecare •Hospice •Diabetes Education •Medical Transport •Medical Equipment •Counseling
Private Duty Nursing •Geriatric & Wound Care Clinic •Pharmacy •Physician Home Visits •Community Outreach