Social Work Advantage

Health Proxy Services

PATIENT REFERRAL FORM

Name of Patient: ____

Location of Patient (room/facility): ____

Name of Hospital or Hospice referring patient to Social Work Advantage:

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Reason for referral: (include diagnosis and admission date):

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What have you, the referring facility, done to find family?

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

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Is the patient on mechanical support? _____________________________________

Is the patient Covid-19 positive? ____

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 phone)**

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

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