PRE-ADMISSION CHECKLIST

REFERRAL RECEIVED AT TIDEWELL (DATE/TIME)	TEAM
VISIT TO FACILITY (DATE/TIME)	FACILITY NAME

(PLEASE PRINT)

PATIENT NAME	**PATIENT NUMBER**

Has been referred to Tidewell Hospice. The following steps have been taken thus far:

ACTION	**DATE**
☐ MD order confirmed	______
☐ Hospice diagnosis	______
☐ If patient is skilled or receiving Part B Medicare: PT, OT, ST	
☐ Skilling or therapy diagnosis	______
☐ End date	______
☐ Dual diagnosis	______
☐ Facility staff reports active pain or symptom issues	______
☐ Patient can sign consents	______
☐ Admission scheduled (date/time)	______
☐ Healthcare surrogate contacted (e.g. POA, guardian, family member)	______
☐ Name/relationship to patient	______
☐ Message left	______
☐ Consents faxed	______
☐ Consents obtained	______
☐ Appointment scheduled (date/time)	______

COMMENTS: Outstanding issues/concerns ______________________________

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If you have any questions or need additional information, please call:

____

NAME/CONTACT NUMBER

Admission's Phone: 941-894-1777
Admission's Fax: 941-894-1780

***NOTE:** Tidewell Admitting RN - please return this form to the Admissions Office at Rand when admission is completed.*