



A Program  
of  
JGS

**Spectrum**  
Home Health  
and Hospice Care

# Request for Home Care and Hospice Services Spectrum Home Health and Hospice Care

(413) 567-4600 Fax: (413) 567-3782

770 Converse Street, Longmeadow, MA 01106

## Patient Demographics

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Phone: \_\_\_\_\_ Alternate #: \_\_\_\_\_ Sex: \_\_\_\_\_

Address: \_\_\_\_\_ Apt: \_\_\_\_\_

City: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Lives:  Alone  With \_\_\_\_\_  
*(relationship)*

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Marital Status: M W D S Primary Language: \_\_\_\_\_

## Insurance

Primary Insurance: \_\_\_\_\_ Policy/Medicare #: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_ Policy #: \_\_\_\_\_

## Medical

Diagnosis: \_\_\_\_\_ Homebound?  Yes  No  
 Unknown

Medical History: \_\_\_\_\_

Allergies: \_\_\_\_\_

Services Requested  Nursing \_\_\_\_\_

*Please include  
reason for  
services*

Physical Therapy \_\_\_\_\_

Hospice \_\_\_\_\_

Other \_\_\_\_\_

Physician Ordering: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

*MD Signature*

Is this the PCP?  Yes  No (if not, who is PCP?) \_\_\_\_\_

Office Contact Person: \_\_\_\_\_ Phone: \_\_\_\_\_

Please fax **MEDICATION LIST** along with this form to (413) 567-3782. Call 567-4600 to let us know you have faxed.

Referred by: \_\_\_\_\_ Date: \_\_\_\_\_ **Thank You!**  
*Name Title*