Nevada Senior Services, Inc.
Hospital 2 Home
901 N. Jones Blvd. Las Vegas, NV 89108
(702) 333-1539
Brussell@nevadaseniorservices.org

HOSPITAL2HOME REFERRAL FORM

Date: _____

Referral by: _____ **Phone #:**_____

Name of Agency: _____ **Email:** _____

Participant Information

Participant Name: _____
Hospital: _____ Patient Room Number:_____
Diagnosis: _____Reasons for Admission:_____
☐ Check if primary contact

Family Caregiver Information

Family Caregiver (CG) Name/Relationship: _____
CG Home Phone #: _____ CG Cell Phone #: _____
☐ Check if primary contact

Hospital 2 Home Eligibility Criteria

1. Patient 60+ or with intellectual or developmental disabilities
   - Does the patient live alone? ☐ Yes ☐ No
   - Does the patient have moderate to severe dementia? ☐ Yes ☐ No
   - Does the patient with I/DD have ADRD or at high risk for dementia? ☐ Yes ☐ No
   - Does the patient or caregiver need assistance with behavioral symptoms? ☐ Yes ☐ No

Has the patient or caregiver been effected by, exposed to or socially isolated due to COVID-19

☐ **Yes** ☐ **No** unknown- family has been isolated

2. What is the Consumer's Insurance?
   - ☐ Medicare
     - ☐ A ☐ B ☐ C ☐ D
   - ☐ Medicaid
   - ☐ Veterans Benefit
   - ☐ Other Insurance
   - ☐ Medigap
   - ☐ Private Insurance
   - ☐ Tricare
   - ☐ No Insurance

3. Destination After Hospitalization: _____

Please fax or email to:
Nevada Senior Services
Hospital 2 Home
Email: Brussell@nevadaseniorservices.org
Fax: (702) 648-1408