Your Hospital's Logo Here

HOME HEALTH CARE REFERRAL FORM

PATIENT NAME:			MR #:
ADDRESS:		APT #:	TEL #:
CITY:		STATE:	ZIP:
REFERRAL TO:	D.O.B.:	AGE:	M ☐ F ☐ Marital Status S M W D	SSN:

MEDICARE ID #:	A & B	A	B	RELATIVE / GUARDIAN:	RELATIONSHIP:
MEDICAID ID # & CODES:				ADDRESS: / APT #:	TEL #:
BLUE CROSS #:	GROUP #:			CITY: / STATE:	ZIP:
OTHER INSURANCE (Name & Address):				DATE ADMITTED:	DATE DISCHARGED:
INSURANCE #:	GROUP #:			TRANSPORT BY: ☐ Car ☐ Ambulance / CLINIC / DR APPTS:	DATE: / Milit. TIME:

DIAGNOSIS - Primary & Secondary: (Include Surgery performed and date, allergies, and / or infections):

PROGNOSIS:

Patient aware of diagnosis? ☐ YES ☐ NO

Family aware of diagnosis? ☐ YES ☐ NO

TO BE COMPLETED BY DOCTOR AT DISCHARGE

TREATMENTS and FREQUENCY	MEDICATIONS	DOSE	FREQUENCY
DIET			

HOME HEALTH SERVICES: ☐ NURSING THERAPY ☐ PHYSICAL THERAPY ☐ OCCUPATIONAL THERAPY ☐ SPEECH THERAPY ☐ SOCIAL WORK ☐ HH-AIDE ☐ OTHER (Specify)

PHYSICAL THERAPY

Restrict Activities? ☐ YES ☐ NO

Sensation Impaired? ☐ YES ☐ NO

☐ Weight Bearing Stams ☐ Non-Weight ☐ Partial Weight ☐ Full Weight

Specific Treatment & Frequency:

Anticipated Goals:

Rehabilitation Potential:

CERTIFICATION

CERTIFICATION FOR HOME HEALTH CARE

Services above needed to treat condition for which patient was hospitalized. ☐ YES ☐ NO

I certify that the above named patient is:

☐ Under my care (or has been referred to another physician having professional knowledge of the patient's condition) is home bound except when receiving outpatient services: requires skilled nursing care on an intermittent basis or physical or speech therapy as specified in the orders due to: ____________

☐ Requires skilled nursing care on a continuing basis for any of the conditions for which he/she received care during this hospitalization.

Signed: ____________

Print Name: ____________

Tel #: ____________ Date: ____________

Will Follow? ☐ Yes ☐ No If "No", Who? ____________

Physician to follow case listed below:

Name: ____________

Address: ____________

PART OF THE MEDICAL RECORD

NURSING

	Self-Care Status Check Function Lvl	Indepen-dent	Needs Assist	Unable
AMBULATION	Bed to Chair			
	Walking			
	Stairs			
	Wheelchair			
	Crutches			
	Walker			
	Cane			
ACTIVITIES	Bathe Self			
	Dress Self			
	Feed Self			
	Brushing Teeth			
	Shaving			
	Toilet			
	Commode			
	Bedpan / Urinal			

DISABILITIES	IMPAIRMENTS
☐ Amputation	☐ Speech
☐ Paralysis	☐ Hearing
☐ Contractures	☐ Vision
☐ Decubitus	☐ Sensation
☐ Other	☐ Other

COMMUNICATIONS	BEHAVIOR
☐ Unable to Write	☐ Alert
☐ Unable to Speak	☐ Forgetful
☐ Understands Speech	☐ Noisy
☐ Understands English	☐ Confused
If "No", Specify Language:	☐ Withdrawn
☐ Reads	☐ Wanders
☐ Other	☐ Other

OTHER

Bowel & Bladder Program ☐ Yes ☐ No

Incontinence ☐ Bladder ☐ Bowel

Date of Last Enema:

Date of Last BM:

Urinary Catheter ☐

Type ____________________ Size ___________

Date Last Changed:

Colostomy ☐

PATIENT CARE PLAN (Explain details of care treatments, teaching of patient and family, habits, preference and goals)

EQUIPMENT / SUPPLIES (Indicate if sent or arranged for)

Signed: ______________ RN Tel #: ______________ Date: ______________

SOCIAL INFORMATION - Adjustment to disability emotional support from family (motivation for self care, socializing abilities, family health problems, financial plan, other agencies referred to, etc.)

IDENTIFIED PROBLEMS:

Signed: ______________ Title: ______________ Tel #: ______________ Date: ______________

THERAPIES - PT, OT, Speech Instructions enclosed ☐ Yes ☐ No

Signed: ______________ Title: ______________ Tel #: ______________ Date: ______________

NUTRITION - Discuss food preferences, understanding of diet, teaching needs and goals. Diet enclosed: ☐ Yes ☐ No

Signed: ______________ Title: ______________ Tel #: ______________ Date: ______________

PSRO - Pre Certification (LOC Coverage for) Agency: By:

Signed: ______________ Title: ______________ Tel #: ______________ Date: ______________

PART OF THE MEDICAL RECORD