Home Health Referral

Please attach additional demographic information, routine notes/ H&P and current medication list. Please fax completed form to 1.706.475.5570.

Patient Information:

Name:________________ **DOB:**________ **SS#:**__________ **Phone:**__________ **Cell #:**__________

Address:________________ **City:**______________ **County:**______________ **Zip:**________

Ordering Physician:______________ **Insurance:**____________________ **ID #:**__________

Emergency Contact Name and Phone #:________________________________

Referral Contact Name:__________________ **Phone #:**__________ **Fax #:**__________

Primary Care Physician Name:__________________ **Phone #:**__________ **Fax #:**__________

1. Please complete sections 1 - 4.

Date of Office Visit:_____/_____/______ Diagnosis:________________________________

If the attached note does not explain how the patient will benefit from home health, please *__describe__*:________________________________

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Examples: Recent functional decline, needs monitoring or teaching of recent plan of care charges (describe please) __AND__ please state what improvements you expect as a result of home health services.

2. Please check at least one impact of the patient's ability to leave home:

- ❑ Uses one or more of the following: cane, wheelchair, walker, medical transport van or ambulance.
- ❑ Has weight bearing restrictions of:________________________________
- ❑ Requires supervision or assistance of another person to leave home safely.
- ❑ Temporarily medically restricted to home because of recent illness, surgery or above diagnosis.
- ❑ Has increased shortness of breath when ambulating distances less than 20 feet.
- ❑ Ambulation is painful or difficult, making patient at increased risk for falling.
- ❑ Deteriorating mental status or other physical condition makes leaving home unsafe without constant supervision.
- ❑ Other:________________________________

3. Orders - Please check all home health services requested:

- ❑ Nursing for teaching, assessment, observation, medication management, disease management or for treatments checked below:
  ❑ Catheter care ❑ Infusion ❑ Wound Care ❑ Trach Care ❑ Ostomy Care

Include specifics of treatment for Labs, IVs, Wounds, Etc.:________________________________

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- ❑ Physical Therapy: Evaluate and treat to restore function due to recent functional status changes.
- ❑ Speech Therapy: Evaluate and treat to restore function for swallowing, cognitive or language abnormalities.
- ❑ Occupational Therapy: Evaluate and treat to restore function due to recent functional status changes.
- ❑ Home Health Aide: to assist with ADLs and personal care needs
- ❑ Other orders:________________________________

4. Physician Signature Required:

____________________	____________________	__________	__________
Physician Signature	**Physician Name (PRINT)**	**Date**	**Time**

Verbal Order Taken by/Discipline:________________________________