HOME HEALTH REFERRAL

Thank you for your referral! Please fax this referral sheet with the following:
1) H&P / Discharge Summary, 2) Current Medication List, 3) *Medicare patients only*: completed Medicare Certification ("Face to Face")

EMPOWER
HOME HEALTH CARE

Patient Demographics

First Name			Last Name			M.I.	
Date of Birth		Sex ☐ M ☐ F	Home Phone		Mobile Phone		
Home Address	Street			City		Zip	
Service Location (if not home address)	Street			City		Zip	
Caregiver / Emergency Contact				Phone			
Insurance	☐ Medicare ☐ Medi-Cal ☐ Commercial Insurance:				ID #		
Diagnosis(es)							

Home Health Orders

Please Check All Home Health Services Ordered:

☐ Skilled Nursing, Evaluate & Instruct:
- ☐ Cardiac ☐ Diabetes
- ☐ Home Health Aide ☐ Medication
- ☐ Pain ☐ Respiratory
- ☐ Advanced Illness Management (AIM) / Palliative Care
- ☐ Wound Care:
  - Type: _____
  - Location(s): _____
  - _____
  - Stage: _____

☐ Physical Therapy, Evaluate & Instruct:
- ☐ Ambulation / Gait ☐ Balance
- ☐ Bed Mobility ☐ Range of Motion
- ☐ Safety / Falls ☐ Transfers
- ☐ Weakness / Strengthening
- ☐ Wheelchair Mobility
- ☐ Other: _____
  - _____
  - _____

☐ Speech Therapy, Evaluate & Instruct:
- ☐ Cognition ☐ Hearing
- ☐ Language Processing
- ☐ Swallowing
- ☐ Voice Intelligibility
- ☐ Other: _____
  - _____
  - _____

☐ Home Infusion (please attach orders separately)

☐ Comprehensive Joint Replacement (CJR) Pre-Op Coordination Visit
Note: available for contracted Sutter hospitals only

Scheduled Surgery Date: _____
☐ TKR ☐ THR ☐ Posterior ☐ Anterior

☐ Medical Social Work, Evaluate & Instruct:
Note: to order MSW, either Skilled Nursing, Physical Therapy, or Speech Therapy must also be ordered.
- ☐ Family Support System
- ☐ Alternate Living ☐ Counseling Referral
- ☐ Stress/Coping/Grief ☐ In-Home Assistance
- ☐ Unsafe Environment
- ☐ Other: _____

☐ Occupational Therapy, Evaluate & Instruct:
- ☐ ADLs ☐ Energy Conservation
- ☐ Sensory Dysfunction ☐ Orthotics
- ☐ Equipment & Adaptive Devices
- ☐ Other: _____
  - _____
  - _____

Comments:

Physician Information

Referring Physician (please print)		Phone Fax
Following Physician (please print, if different)	☐ same as referring physician above	Phone Fax
Physician Signature	*By signing, I am confirming referral orders and diagnosis listed:*	Date

FAX TO : (818) 616-1110