

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")

Patient Demographics	First Name		Last Name		M.I.		
	Date of Birth		Sex <input type="checkbox"/> M <input type="checkbox"/> F	Home Phone	Mobile Phone		
	Home Address	Street			City		Zip
	Service Location <small>(if not home address)</small>	Street			City		Zip
	Caregiver / Emergency Contact				Phone		
	Insurance	<input type="checkbox"/> Medicare <input type="checkbox"/> Medi-Cal <input type="checkbox"/> Commercial Insurance:				ID #	
	Diagnosis(es)						
Home Health Orders	Please Check All Home Health Services Ordered:						
	<input type="checkbox"/> Skilled Nursing, Evaluate & Instruct: <input type="checkbox"/> Cardiac <input type="checkbox"/> Diabetes <input type="checkbox"/> Home Health Aide <input type="checkbox"/> Medication <input type="checkbox"/> Pain <input type="checkbox"/> Respiratory <input type="checkbox"/> Advanced Illness Management (AIM) / Palliative Care <input type="checkbox"/> Wound Care: Type: _____ Location(s): _____ Stage: _____		<input type="checkbox"/> Physical Therapy, Evaluate & Instruct: <input type="checkbox"/> Ambulation / Gait <input type="checkbox"/> Balance <input type="checkbox"/> Bed Mobility <input type="checkbox"/> Range of Motion <input type="checkbox"/> Safety / Falls <input type="checkbox"/> Transfers <input type="checkbox"/> Weakness / Strengthening <input type="checkbox"/> Wheelchair Mobility <input type="checkbox"/> Other: _____		<input type="checkbox"/> Speech Therapy, Evaluate & Instruct: <input type="checkbox"/> Cognition <input type="checkbox"/> Hearing <input type="checkbox"/> Language Processing <input type="checkbox"/> Swallowing <input type="checkbox"/> Voice Intelligibility <input type="checkbox"/> Other: _____		
	<input type="checkbox"/> Home Infusion (please attach orders separately)		<input type="checkbox"/> Medical Social Work, Evaluate & Instruct: <i>Note: to order MSW, either Skilled Nursing, Physical Therapy, or Speech Therapy must also be ordered.</i> <input type="checkbox"/> Family Support System <input type="checkbox"/> Alternate Living <input type="checkbox"/> Counseling Referral <input type="checkbox"/> Stress/Coping/Grief <input type="checkbox"/> In-Home Assistance <input type="checkbox"/> Unsafe Environment <input type="checkbox"/> Other: _____		<input type="checkbox"/> Occupational Therapy, Evaluate & Instruct: <input type="checkbox"/> ADLs <input type="checkbox"/> Energy Conservation <input type="checkbox"/> Sensory Dysfunction <input type="checkbox"/> Orthotics <input type="checkbox"/> Equipment & Adaptive Devices <input type="checkbox"/> Other: _____		
	<input type="checkbox"/> Comprehensive Joint Replacement (CJR) Pre-Op Coordination Visit <i>Note: available for contracted Sutter hospitals only</i> Scheduled Surgery Date: _____ <input type="checkbox"/> TKR <input type="checkbox"/> THR <input type="checkbox"/> Posterior <input type="checkbox"/> Anterior		Comments:				
Physician Information	Referring Physician <small>(please print)</small>				Phone		
	Following Physician <small>(please print, if different)</small>	<input type="checkbox"/> same as referring physician above			Fax		
	Physician Signature	<i>By signing, I am confirming referral orders and diagnosis listed:</i>			Date		