Vital Care Health Systems

Where Caring Comes From The Heart

HOME HEALTH REFERRAL FORM

INFORMATION OF PATIENT					
Name:				Phone:	
Address:					
SS#		Date of Birth:		Gender:	Male ☐ Female ☐
Insurance:	Medicare #		Medical#		Other
Emergency Contact				Phone:	
Diagnosis:					
Homebound Due To: ☐ Draining Wound ☐ Weakness ☐ Bed-bound/Non-Ambulatory ☐ Poor Endurance/Easy Fatigue/Shortness Of Breath ☐ CV Instability ☐ Severe Pain ☐ Metabolic Instability ☐ Unable to leave Unassisted ☐ Confused ☐ Disoriented ☐ Respiratory Instability ☐ OTHERS _____					

HOME HEALTH ORDERS

(Place check marks for disciplines medically necessary for home health service).

SKILLED NURSING				
Skilled Observation / Instruction:	☐ Cardiac	☐ Diabetic	☐ Pain	☐ Respiratory
	Wound Care: ☐ Pressure Ulcer	☐ Stasis Ulcer	☐ Surgical	☐ Other
	Labs: ☐ Baseline	☐ As Needed	☐ Routine/Frequency:	
	☐ IV Therapy	☐ Tube Feeding		
	☐ Medication Therapy Management	☐ Others:		
	☐ Home Health Aide	☐ Personal Care	☐ Assist with ROM	
In order to receive Occupational Therapy or Medical Social Worker, a patient MUST have either Skilled Nursing, Physical Therapy or Speech Therapy on the case.				

PHYSICAL THERAPIST			
Evaluation/ Instruction:	☐ Ambulation/Gait	☐ Bed Mobility	☐ Lower Extremities Range of Motion
	☐ Balance/Vestibular (Safe Strides)	☐ Durable Medical Equipment Evaluation	
	☐ Assistive Device Use (Cane, Walker, Wheelchair)	☐ Safety / Fall Risk	
	☐ Strengthening	☐ Others	

OCCUPATIONAL THERAPIST			
Evaluation/ Instruction:	☐ ADLs /Work Simplification	☐ Energy Conservation	☐ Fine Motor Control
	☐ Upper Extremities Range of Motion	☐ Durable Medical Equipment Evaluation	
	☐ Splinting / Adaptive Equipment	☐ Others	

SPEECH THERAPIST			
Evaluation/ Instruction:	☐ Swallowing	☐ Cognition	☐ Hearing
	☐ Language Processing	☐ Voice Intelligibility	☐ Others

MEDICAL SOCIAL WORKER			
Evaluation/ Instruction:	☐ Community Resources Set-up for	☐ IHSS	☐ Medical
		☐ Meals-on-Wheels	☐ Living Arrangements
	☐ Counseling for	☐ Crisis Intervention	☐ Loss of Significant Other
		☐ Terminal Care	☐ Crisis Intervention ☐ Familial Problem
		☐ Long Term Planning	☐ Others

REGISTERED DIETICIAN			
Evaluation/ Instruction:	☐ Medical Nutrition Therapy	☐ Weight Management	☐ Others

Comments:	
DME	

Name of Physician			
Signature of Physician		Date:	
Phone No.		Fax No.	

The patient is currently under my care and I have authorized the home health services based on approved plan of care.

Vital Care Health System
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