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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