South Peninsula Hospital

Tel: 907.235.0369
Fax: 907.235.0810

HOME HEALTH REFERRAL ORDERS

Please attach demographic sheet if patient information is not completed. Please attach the Face to Face visit note for Medicare patients.

Today's date:	Referring Physician:

PATIENT INFORMATION

Patient's Last name:	First:	Middle	☐ Mr. ☐ Mrs.	☐ Miss ☐ Ms.	Marital Status (circle one) Single / Mar / Div / Sep / Wid

Street address:	Social Security no.:	Birth date: / /	Age:	Sex: ☐ M ☐ F

City:	State:	Zip Code:	Home phone no.: ( )

Family Contact:	Phone:	**Date of Face to Face Encounter:**
Caregiver Name:	Phone:	

Is a caregiver willing and able to learn and provide patient care? ☐ Yes ☐ No	Primary Diagnosis:	Primary Insurance: ☐ Medicare Number: _____ ☐ Medicaid Number: _____ ☐ Other: _____
Allergies		

Code Status: ☐ Full Code ☐ DNR ☐ Comfort One in place

Prognosis: ☐ Good/Excellent ☐ Fair ☐ Poor/Guarded

SKILLED SERVICES

Skilled Nurse Evaluation

☐ SN Evaluation and 1-3 visits/week x 9 weeks and 3 PRN visits to troubleshoot issues r/t care needs.

☐ New Diagnosis
☐ Wound Care
☐ Disease Process Education
☐ Medication Management/Instruction
☐ Catheter Care *Type:* _____
☐ Diabetes Teaching

Call MD for BS <_____ or >_____

☐ Pain Management
☐ IV Care per HH protocol

Type of Access: _____

☐ Other _____

Physical & Occupational Therapy Evaluation

☐ PT Evaluate and Treat: 1-3 visits/week x 9 weeks
☐ OT Evaluate and Treat: 1-3 visits/week x 9 weeks
☐ New Fracture ☐ Energy Conservation
☐ Frequent Falls ☐ New Decline in ADLs
☐ Transfer/Gait Training ☐ Home Safety Evaluation
☐ Home Exercise Program/Functional Mobility
☐ Edema Therapy ☐ New Generalized Weakness
☐ Other _____

Weight Bearing Status/Precautions:

_____

Speech Therapy Evaluation

☐ Evaluate and Treat: 1-3 visits/week x 9 weeks

☐ Dysphagia
☐ Dysphasia
☐ Impaired Cognition
☐ Other _____

Other

☐ MSW evaluation

☐ Home Health Aide

WRITTEN ORDERS (LAB ORDERS, WOUND CARE ORDERS, TREATMENTS, ETC.)

In addition to the above, each ordered discipline will provide Pulse Oximetry PRN per clinician assessment. Each ordered discipline will report to MD T> 101.0, HR>130 or <50, RR<10, SPO2%<90, SBP>200 or <90, DBP>95 or <50.

I certify that, based on my findings, this patient is in need of intermittent skilled nursing care, physical therapy and/or speech therapy, and a Plan of Care furnishing these services to include, but not limited to SN, PT, OT, ST, MSW or HHA. I have authorized the services on this initial order.

Physician signature: _____ Date/Time: _____

Physician ordered Start of Care date: _____ (required if aplicable)

PCP Physician to Physician hand off: ☐ YES ☐ NO Date/Time: _____

If referring physician will not be signing Home Health orders, please list MD that will be signing and overseeing POC.

_____ **Verified on:** _____