VITACARE HOME HEALTH SERVICES
Building a healthy Community one individual at a time

Home Health Services Request
REFFERAL AUTHORIZATION FOR PLAN OF CARE

PATIENT DEMOGRAPHICS	Referring Agency		Requested SOC Date:	
Patient's Name: (Last, First):				
Patient Address:	Apt:		Zip Code:	
Phone:	Gender: ☐M ☐F	Age	DOB:	SS#
Marital Status: ☐M ☐S ☐W ☐D ☐SEP	Primary Language: ☐English ☐Spanish ☐Russian ☐Other		Understands English Yes No	
Facility Admit Date:	Facility Discharge Date:			

EMERGENCY CONTACTS

Name: ______	Name: ______
Address: ______	Address: ______
Phone: ______	Phone: ______
Relationship: ______	Relationship: ______

FINANCIAL INFORMATION

Payer	☐**Medicare**☐ **Medicaid**☐**Insurance** ☐**Private Pay**☐**Other**
Medicare #:	**Insurance Name:**
Medicaid #:	**Card Number #:**

MEDICAL INFORMATION

Primary MD or Psychiatrist for follow up care in the community:	
Address:	**Phone #:**
License #:	**Record #:**

PRIMARY DIAGNOSIS	**Date:**
Other Diagnosis:	**Date:**
Surgical Procedure(s):	**Date:**
PROGNOSIS: ☐**Good** ☐**Fair** ☐**Poor**	**Date:**

REASON OR HOSPITALIZATION (if applicable) and referral to VitaCare Home Health services, include chief complaint, medical history, and course of treatment**.**

______

______

______

SOCIAL ASSESSMENT /SUPPORT SYSTEM (Include safety and environmental concerns, pets, etc.)

______

______

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MEDICATIONS	ALLERGIES				
Name	Dose	Frequency	Route		VITAL SIGN RANGE
					BP Pulse Temp
					HT WT Resp
					Pain (1-10 scale:)
					Parameters to call MD:
					BP<_________> __________
					Glucose < _________ > ________
					Labs:
					Cognitive:
					Diet/Nutritional Requirements

Functional Limitations: ☐Ambulation ☐Paralysis ☐ Legally Blind ☐Bowel/Bladder ☐Endurance ☐Dyspnea with minimal Exertion ☐Contracture ☐ Ambulation ☐Hearing ☐Speech ☐Other (Specify)

Activities Permitted: ☐1 complete Bed Rest ☐2 Bed Rest BRP ☐3 Up as tolerated ☐ 6 Partial Weight Bearing

SKILLED SERVICES (Check predicted service need)

SN	☐New Diagnosis ☐DM Care_______________ ☐Cardio/Pulmonary ☐Behavioral Health	☐Exacerbation of: ______________ ☐Cardio/Pulmonary ☐Gastrointestinal/Genitourinary Care ☐Neuro Care ☐Telehealth: ________
THERAPY	☐Physical Therapy ☐ Occupational Therapy ☐Speech Therapy	
NUTRITION	☐Instruct on Prescribed Diet ☐Counsel re: Compliance with Diet ☐Other:_____________	
MSW	☐Problem resolution associated with crisis ☐Inadequate food/medical supplies ☐Other:____________________________	☐Need for alternate housing ☐Abuse/Neglect ☐Entitlement assessments, applications and follow-up
AIDE	☐ADL Assistance ☐Shop/Prepare Meals ☐Accompany to MD/Clinic app'ts	☐Remind to take medications ☐Light House keeping

DME & SUPPLIES

DME/Supplies – Equipment in home:
New Equipment Ordered by referrer: (Include item description, date ordered, and vendor)
Requested items for VitaCare Home Health Services to order:

Referral Initiated by: (print name & title):	Phone/Pager: Date:

Physician Signing POC: ______________________________ Phone/Pager: ________________ Date:______________

Physicians Name: __________________________________ License #: ____