ALARS
HOME HEALTH, LLC

Tel: (916) 648-1120 Fax: (916) 993-4815

HOME HEALTH REFERRAL FORM

Patient Information:

Name: _____ DOB: _____ ☐ F ☐ M

Address: _____

Phone: _____ Cell Phone: _____

Contact Person: _____ Contact Phone: _____

Insurance Information:

Medicare ID: _____ Medi-Cal ID: _____

HMO Plan ID: _____ Private Insurance ID: _____

Home Health Orders:

☐ RN Evaluation & Follow up

- ☐ Post-Op dressing change
- ☐ Staples /sutures removal
- ☐ I.V. Infusion and teaching
- ☐ Decubitus care/open wound care
- ☐ PT/INR, laboratory
- ☐ Diabetic teaching/insulin
- ☐ PICC line care/ Foley care
- ☐ Other: _____
- ☐ IM, SC, injections
- ☐ Medication management
- ☐ Disease management

☐ Physical Therapy Evaluation and Follow up

- ☐ Home safety/Fall prevention
- ☐ Therapeutic exercise
- ☐ Transfer training
- ☐ Other: _____
- ☐ Gait training
- ☐ Muscle strengthening
- ☐ ROM exercises
- ☐ Muscle re-education
- ☐ Establish HEP
- ☐ DME Assessment

☐ Occupational Therapy Evaluation and Follow up

- ☐ Muscle re-evaluation
- ☐ Adaptive equipment
- ☐ Other: _____
- ☐ Therapeutic exercise
- ☐ ADL training
- ☐ Establish HEP

☐ Medical Social Worker Evaluation and Follow up

- ☐ Evaluate family situation
- ☐ Medical directive set up
- ☐ Other: _____
- ☐ Evaluate financial status
- ☐ Refer to community resources
- ☐ Evaluate emotional factors
- ☐ Crisis intervention

☐ Certified Home Health Aide

- ☐ Personal care and ADL assistance

☐ Other Instruction: _____

Physician Information:

Name: _____

Phone: _____ Fax: _____

Address: _____

Signature: _____ Date: _____

The Joint Commission
National Quality

CAHSAH
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MEMBER