



Fax: 920.966.0334 Phone: 920.237.6242

Evergreen At Home-Home Health Referral Form

Date of Referral:		Name Referring:		Phone:	
Referred Patient Information					
Anticipated Date of Discharge from facility:					
Patient Name:		Patient SS#:			
Address/Service Location:			City:		
			<input type="checkbox"/> Male <input type="checkbox"/> Female		
Zip:		County:		DOB:	
Pharmacy:					
Living Situation:	<input type="checkbox"/> Alone <input type="checkbox"/> Spouse <input type="checkbox"/> Friend <input type="checkbox"/> Family <input type="checkbox"/> Other (CBRF, RCAC):				
Emergency Contact:				Relationship:	
Emergency Contact Number:					
INSURANCE INFORMATION					
Medicare#:			Medicaid#:		
Private/Medicare Replacement Insurance:					
<input type="checkbox"/> Network Health Plan <input type="checkbox"/> BC&BS <input type="checkbox"/> Tri-Care <input type="checkbox"/> Other:					
Provide copy of Cards					
Home Care Services:	<input type="checkbox"/> Skilled Nursing		<input type="checkbox"/> Physical Therapy Eval and Tx		<input type="checkbox"/> Occupational Therapy Eval and Tx
<input type="checkbox"/> Admit to Home Health	<input type="checkbox"/> Speech Therapy Eval and Tx		<input type="checkbox"/> Medical Social Worker Eval and Tx		<input type="checkbox"/> Home Health Aide
Medical and Social History					
Primary Dx and Surgical Procedure Information:					
Ambulation Status:	<input type="checkbox"/> IND w/assistive device <input type="checkbox"/> W/C bound <input type="checkbox"/> IND w/o Assistive Device				
Therapy Home Evaluation completed:	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes: Attach copy				
Current Wound Care Tx:					
Anticoagulation Mgmt:	Physician Ordering Coumadin/Warfarin Dosing			Next Scheduled Pt/INR:	
<input type="checkbox"/> Yes <input type="checkbox"/> No					
Current Coumadin Dose:					
Other upcoming scheduled lab work:					
Physician Signature:				Date:	
Physician Print Name:				Fax:	

Please call 920.237.6242 to confirm referral received. Thank you. Please fax additional pertinent information if available, face sheet, H & P, D/C Summary, Orders, Therapy Notes, etc...

For Office Use Only		
Entered in Axxess	Authorization Completed (if required)	Admit Date Scheduled with Patient
Date/Initial	Date/Initial	Date/Time/Initial