INTAKE REFERRAL

Home Health Care Network

Phone (713) 783-8049 ♦ Fax (713) 783-6941 ♦ 1-800-858-2889

Medical Record # _____ **Admitting, Nurse** _____

DATE:_____ TIME: _____ TAKEN BY: _____

REFERRAL SOURCE: _____ PHONE #: ( ) _____ - _____

PATIENT NAME:_____ ☐ M ☐ F DOB: _____
Last First Middle M/S/D/W/U

ADDRESS: _____
Street Apt # City State Zip Code

PHONE NUMBER ( ) _____ - _____ ADMISSION DATE _____

DIAGNOSIS: _____

PATIENT LIVES WITH:_____
NAME, RELATIONSHIP AND TELEPHONE NUMBER

EMERGENCY CONTACT:_____
NAME, RELATIONSHIP AND TELEPHONE NUMBER

MEDICARE #: _____ - _____ - _____ ____ SSN#: _____ - _____ - _____

VERIFIED_____ PRIOR EPISODE: _____

OTHER PAYER:_____
NAME, TELEPHONE AND CASE MANAGER NAME IF APPLICABLE

INSURANCE POLICY #: _____ GROUP #: _____

EMPLOYER:_____
NAME AND TELEPHONE NUMBER

ORDERS FOR HOME CARE

☐SN ☐HCA ☐PT ☐OT ☐SLP ☐MSW

DME NEEDED: _____

PROVIDER IN THE HOME ? ☐YES ☐NO IF YES, HOW MANY DAYS, HOURS?

PHYSICIAN NAME: _____ PHONE #: ( ) _____ -_____

UPIN #: _____ FAX #: ( ) _____ -_____

PHYSICIAN NAME: _____ PHONE #: ( ) _____ -_____

UPIN #: _____ FAX #: ( ) _____ -_____

PT HOSPITALIZED? ☐YES ☐NO IF YES, WHERE:_____

PT LAST SEEN BY PHYSICIAN: _____

Key Map # _____ ☐ADMIT ☐NON ADMIT REASON NON ADMIT:_____