REMEMBER: Ask for H & P, Operative Report **Primary Nurse:** _____

Clinical Record #: _____ **Admitting Nurse:** _____

MD Specifically Orders SOC (MO102): _____

JEFFERSON COUNTY PUBLIC HEALTH SERVICE
REFERRAL FORM
(NOT for PRI/PCW use)

Patient Information:

Name: _____ **DOB:** _____ **Sex: M** _____ **F** _____
LAST FIRST MI

Address (No P.O. Boxes): _____ **Social Security #:** _____

_____ **Telephone: (h)**_____**(c)** _____

Medicare #: _____ **Medicaid:** _____

Private Insurance or Medicare Replacement Plan Name/Address/Phone/Subscriber #: _____

_____

DME Name/Address/Phone: _____

_____

Contact In An Emergency - Name/address/phone/relationship: _____

_____

Referral Source*: (Person) _____ **Hosp** _____ **MD** ____ **Family*** _____ **Community** _____

(Agency) _____ **SNF** _____ **Acute Inpatient Rehab** _____

MD Name & Address: _____ **Telephone:** _____

_____ **Telephone:** _____

_____ **Telephone:** _____

_____ **Telephone:** _____

Last MD Encounter (could be hospitalist): _____ **Next MD Appointment:** _____

Discharged from What Type of Facility Within Last 14 Days:
Admission Date: _____ **Discharge Date:** _____

M1000 Which Inpatient Facilities Discharged During Past 14 Days: _____

Name of Facility: _____ **Telephone:** _____

_____ **Telephone:** _____

_____ **Telephone:** _____

Diagnosis for Computer Entry by Secretary: _____ **Code:** _____

In Home DNR: _____ **Yes** _____ **No**

M1005 Inpatient Discharge Date: _____ **M1012 Inpatient Procedure:** _____

Medical Diagnoses: (Past Medical History) _____

_____

Pain Controlled With: _____**? CHF:** _____ **? Depression:** _____

Surgical Diagnoses: _____

Vaccinations Provided: Seasonal Influenza _____ **Pneumococcal** _____ **Tdap** _____

Rx given to patient for supplies? _____

Diet Order: _____ **Last BM:** _____

Allergies: _____ **Weight and Date:** _____

Mental Status: Oriented____ Disoriented____ Depressed____ Agitated____ Comatose____ Other_____

Forgetfulness or Memory Loss _____ Wandering? _____

Urinary Catheter While Hospitalized? □ Yes □ No Skin Integrity _____

History of Urinary Tract Infection? □ Yes □ No Stage of Pressure Wounds _____

Falls in Past Year □ Yes □ No Location of Pressure Wounds _____

Functional Limitations: Ambulation Independent _____ Transfer Bed/Chair _____ Partial Weight Bearing _____

Walker _____ Wheelchair _____ Complete Bedrest _____

**** For Anything Other Than Independent, Ask for P.T./O.T. Referral**

Services Requested:

□ SN – Evaluation Visit & 1 Visit

□ O.T. – Evaluation Visit & 1 Visit

□ P.T. – Evaluation Visit & 1 Visit

□ S.T. – Evaluation Visit & 1 Visit

□ MSW – Evaluation Visit & 1 Visit

□ HHA Visits Per Week _____

Informal Support: □ Available □ Willing to Assist □ Unavailable

Clinical Findings: _____

Medication	Dose	Frequency	Route	(N) New	(C) Change

Signature of Person Completing Referral **Time** **Date**

Physician's Signature **Date**

GH:blp

Phnadmin/bridget/forms/Home Care Referral 050211