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:
- ☐ Open wound care ☐ Pressure injury care ☐ Post-Op dressing change ☐ Staples /sutures removal
- ☐ Foley care / Suprapubic ☐ Laboratory ☐ I.V. Infusion PICC line care ☐ IM, SC, injections
- ☐ Diabetic teaching/insulin ☐ PT/INR ☐ Disease management ☐ Medication management
- ☐ Other: _____

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

☐ Occupational Therapy Evaluation and Follow up
- ☐ Muscle re-evaluation ☐ Therapeutic exercise ☐ Establish HEP ☐ ADL training
- ☐ Adaptive equipment ☐ Other: _____

☐ Speech Therapy Evaluation and Follow up
- ☐ Swallowing assess. & training ☐ Voice assessment ☐ Functional Cognitive assessment
- ☐ Other: _____

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

☐ Certified Home Health Aide
- ☐Personal care and ADL assistance ☐ Other Instruction: _____

Physician Information:

Name: _____

Phone: _____ Fax: _____

Address: _____

Signature: _____ Date: _____

The Joint Commission
National Quality

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MEMBER