Home Health Care

"Bringing Health Care Services To Your Home"

REFERRAL FORM

Please Fax to 670-233-4648

Patient's Name: _____ Date of Birth: _____

Address: _____ Contact No.: _____

Primary Insurance: _____ Primary Ins. #: _____

Secondary Insurance: _____ Secondary Ins. #: _____

Primary Caregiver: _____ Contact No.: _____

Physician: _____ UPIN: _____

Primary Diagnosis: _____

Medical History: _____

MENTAL STATUS: (check all that apply)

☐ Alert ☐ Comatose ☐ Confused ☐ Disorientated ☐ Depressed ☐ Forgetful

FUNCTIONAL LIMITATIONS: (check all that apply)

☐ Bedridden ☐ Cane ☐ Up as Tolerated

☐ Wheelchair ☐ Walker ☐ Others: _____

SERVICES TO BE PROVIDED: (check all that apply)

☐ Evaluate & Treat
☐ Monitor/Assess Vitals & Physical Status
☐ Wound Care: Site - _____
Procedure - _____
☐ Catheter Care/Change:
Size: _____
Freq: _____
☐ Injection: _____
☐ Supervise/Teach Oral Medications
_____
☐ Diabetic Mgmt: _____
☐ Modalities
☐ Hot Packs
☐ Cold Packs
☐ Electrical Stimulator
☐ TENS
☐ Iontophoresis
☐ Other: _____

☐ Manual Therapy
☐ Soft Tissue Mobilization
☐ Massage
☐ Myofascial Release
☐ Joint Mobilization
☐ Exercise
☐ Active ROM
☐ Passive ROM
☐ Strengthening
☐ CPM
☐ Home Exercise Program

☐ Gait Training
☐ Non Weight Bearing
☐ Partial Weight Bearing
☐ Full Weight Bearing
☐ Walker
☐ Cane
☐ Crutches
☐ Isotonic
☐ Isokinetic
☐ Isometric
☐ Free Weights

MEDIC.	DOSE	FREQ.	ROUTE

SERVICE(S) REQUESTED & FREQUENCY:

☐ RN - _____	☐ PT - _____	☐ OT - _____
☐ HHA - _____	☐ MSW - _____	☐ ST - _____
Frequency of Treatment:		_____/week

Glucose Finger sticks:	
Diet:	
Allergies:	

INSTRUCTIONS: _____

PRECAUTIONS: _____

Prognosis/Rehab Potential: ☐ Good ☐ Fair ☐ Poor

DME Needed (specify): _____

Reason for Referral: _____

MD ORDERS: _____

I, the physician for the said patient, authorize MARIANAS HEALTH SERVICES and/or its subsidiaries to provide home care services for the said patient. This patient is under my care, is confined to his/her home and is in need of homecare services on an intermittent basis. This medical plan of care of this patient will be initiated and re-evaluated at least every sixty- (60) days.

PHYSICIAN'S SIGNATURE: _____ DATE: _____

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"A Locally-Owned, Medicare& Medicaid Certified Home Care Agency"

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