NURSE OWNED & OPERATED
PARRISH HOME HEALTHCARE

PARRISH HOME HEALTHCARE
OFFICE: (248) 352-3400
FAX: (248) 352-2995
PATIENT REFERRAL FORM

HomeCare Elite® AGENCY 2018

PATIENT NAME:_____

DATE OF BIRTH: _____ ☐M ☐F

SSN:_____

ADDRESS: _____

CITY/STATE/ZIP: _____

PHONE: _____

CONTACT NAME/PHONE:_____

_____

REFERRAL DATE: _____

REQUESTED START DATE _____

HEALTH INSURANCE:
PRIMARY: _____
SECONDARY:_____

PRIMARY CARE
PHYSICIAN:_____

PRIMARY DX: _____

OTHER DX: _____

Qualifying Services:
☐Skilled nursing

Special Orders
☐Instruct & assess medications
☐Assess & instruct disease process
☐Lab work (specify) _____
_____
☐Wound Care (specify) _____
_____

Additional Services
☐Physical therapy
☐Speech therapy
☐Occupational therapy
☐Social Worker
☐Home Health Aid
Dietician

FACE TO FACE VISIT

Encounter Date: _____

PLEASE SUBMIT PROGRESS NOTE FOR DATE OF ENCOUNTER, IT MUST INCLUDE HOMEBOUND STATUS AND REASON FOR SKILLED CARE.

MEDICAL ORDERS AND PLAN OF TREATMENT

1. DIET (Check all that apply)
☐ Regular _____Calories
☐ ADA ☐ NA Restrict
☐ Soft ☐ Tube Feeding
RATE: _____/Hr.

2. ACTIVITY ALLOWANCE
_____ BRP
_____ To tolerance
_____ Resume Normal Activity

3. EQUIPMENT
☐Cane ☐ Oxygen
☐ Brace ☐ Prosthesis
☐Walker ☐ Wheelchair
☐ Commode ☐ Feeding Pump

4. MEDICATIONS: (write in) ☐ Check in Home

PHYSICIAL SIGNATURE

Physician Signature: _____ Date: _____

Physician Name (PRINT): _____ Email: _____

Contact at Physician's Office: _____ Phone: _____