PATIENT CARE REFERRAL FORM

SEQUOIA HOME HEALTH

Please Complete and fax the following information to (844) 272-2818
Include: Demographics | Copy of insurance cards | H&P | **Most recent MD Visit note that triggered the Home Health Referral**

PATIENT INFORMATION

Patient Name:_____ DOB:_____ Phone:_____

Address:_____ Alternate Phone:_____

Insurance Type:_____ Insurance #:_____

PCP Name:_____ - Office Contact Name:_____ Contact #:_____

*PATIENT WILL BE OPENED IN 48 HOURS UNLESS A START OF CARE DATE IS SPECIFIED:*_____

DIAGNOSIS/MEDICAL CONDITION: (List the diagnosis/medical condition that is the primary reason the patient requires home health services)

SKILLED SERVICES NEEDED:

SN EVALUATION FOR:		PT EVAULATION FOR		OT EVALUATION FOR:		ADDITIONAL SERVICES:	
	Medication Compliance		Gait/Balance		Train in ADL'S/IADL'S		MSW Eval-Community Services
	Diabetic Care		Transfers		Energy Conservation		ST Eval-Speech/Swallowing
	Ostomy/Foley Care		Bed Mobility				CHHA-Personal care assist.
	G-Tube Feedings		Safety eval				Other: (Describe)
	Wound Care (Describe)		PT/PCG Training Devices (Wheelchair, Walker, Cane)				
	IV Therapy						

ALLERGIES:_____

Physician Name and Signature

Physician's Printed Name:_____

Physician's Signature:_____ Date:_____

☐ **COMPANION CARE SERVICES:** Assistance with ADL'S and other Non-Medical needs including meal prep, Light Housekeeping, Transportation, Companionship and More.
We will contact your patient directly to explain our services and set up a FREE, No obligation assessment. Companion care is *NOT* covered through health insurance, but we can assist your patient with various payment options including credit card, County services, VA Aid &Attendance and long term care insurance plans.

FAX SENT BY:_____ DATE:_____ PHONE:_____ FAX:_____