VNA Home Health
The Perfect Balance of Healing & Home

REFERRAL FORM - Request for Home Health Care Services

Name of Practice/Facility_____ **Type of Facility**_____

VNA Office Phone: 489-2681 *(Call Intake to confirm receipt of faxed referral)* **Fax Number: 489-2532**

Facility Admission Date_____ Facility Discharge Date_____

Patient Name: _____ D.O.B. _____SEX ____ SSN _____
Home Address: _____ Phone: _____
Caregiver Name_____ Phone: _____
Name and Address of community MD (*one to sign orders*) _____
_____ Phone: _____
Principal Diagnosis & date: _____
_____
Other Diagnoses & dates: _____
Surgical Procedures & dates: _____
Last Physician Appointment date: _____Was appointment related to reason for home care referral? ☐ Yes ☐ No.
Please fax: Discharge Summary from Acute Care Facility, Facility H&P, Discharge Medications/Instructions Most Current (only) Rehab Notes.

Health Insurance Information: Medicare#: _____ Medicaid# _____
Other Health Insurance: _____ Policy# _____ Group# _____
Case Manager: _____Phone #_____Authorization # _____
Approval given for: _____

Disciplines/Services ordered: Please circle:
RN HHA PT OT ST Nutrition Social Work Pediatrics RN Maternal Child RN PRI WOCN CHMN
CP Nurse CDE LTHHCP EVAL. (And admit if appropriate) IV RN Telehealth (Evaluate and install if appropriate)

Medications (dose, route and frequency):_____
_____
_____

Allergies: _____ **Diet:** _____

Weight bearing/activities restrictions: _____

Functional Limitations: ☐ Amputation ☐ Speech/Hearing ☐ Legally Blind
☐ Limited Manual Dexterity ☐ Cognitive Impairment

Physicians Orders/Treatments/Instructions:_____
_____
_____
_____

Referral Source: Person making referral: _____
Phone:_____**This referral will be evaluated to determine if patient meets VNA Admission Policy-Intake will contact you with date we may begin service.**

Physician signature/date

_____

* Referral must be signed by MD – Center for Medicare and Medicaid does not recognize Nurse Practitioner or Physician Assistant signatures for homecare services.

AVNA parameters	Vital Signs
B/P: 95/50-180/110	
P: 60-100	
Temp: 97-99.5	
Blood Glucose: 70-180	
O2 Sats: > or = to 90%	
Weight gain: notify MD if > 2lbs in 24 hours or 5 lbs in 7 days	
Date service requested to start:	
Patient Essentially Homebound: Yes ☐ No ☐	