VNA Home Health
The Perfect Balance of Healing & Home

REFERRAL FORM - Request for Home Health Services

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

VNA Phone: (518) 489-2681 *(*Call to confirm receipt of faxed referral)* **Fax: (518) 489-2532**

Facility Admission Date_____ Facility Discharge Date_____ (*Hospitals or Sub-Acute Rehabs Only*)

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 PT OT ST HHA Social Work WOCN CMHRN CPRN
CDE IV RN Nutrition Pediatrics RN Maternal Child RN PRI

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

Allergies: _____ **Diet:** _____

Weight bearing/activities restrictions: _____

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

Physician's 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 ☐	