HOME CARE REFERRAL - HOSPITAL

New ☐ Resume ☐ Change ☐

Case Coordinator: _____

Home Address (include Postal Code): _____

Phone#: _____ Cell#: _____

Can person communicate in English? ☐ YES ☐ NO If "no", language spoken: _____

Local Contact Person: _____ Phone#: _____ Cell#: _____

Next of Kin/Relationship: _____ Phone#: _____ Cell#: _____

Primary Care Practitioner/Ph # _____ Date of Admission: _____

Reason for and course of Hospitalization: _____

MRSA/VRE/Other status: ☐ Positive ☐ Negative ☐ Unknown _____

Living Arrangement:
- ☐ Alone
- ☐ Relatives
- ☐ With Others
- ☐ Homeless

Family Support:
- ☐ Not available
- ☐ Minimal
- ☐ Moderate
- ☐ Complete

Daily Living:

Is the client/or other family members able to:
- Prepare meals: ☐ Yes ☐ No
- Do the shopping: ☐ Yes ☐ No
- Do the housekeeping: ☐ Yes ☐ No
- Arrange satisfying activities: ☐ Yes ☐ No

AMBULATION (✓ all that apply)	CONTINENCE (✓ all that apply)	MENTAL STATUS (✓ all that apply)	PERSONAL CARE (✓ all that apply)				
			Bathing	Dressing	Toileting	Feeding	
_____Independent	_____ Independent	____ Orientated					
_____Standby assist	_____ Continent	____ Forgetful					
_____1 person assist	_____Incontinent, bladder	____ Mild Confusion					
_____2 person assist	_____Incontinent, bowel	____ Disorientated					
_____walker	_____Brief /pad	____ Depressed					
_____wheelchair	_____Indwelling catheter	____Anxious					Independent
_____Mechanical lift	_____Ostomy/Colostomy	____ Unusual behavior					Minimal assist
_____Other_____	_____Urinal	____Other_____					Moderate assist
	_____ Commode						Complete
	_____ Other_____						

Other Agency Involvement: (✓ all that apply and attach report)

☐ OT ☐ PT ☐ Mental Health for Older Adults ☐ Palliative Care ☐ Chronic Disease ☐ Other _____

Anticipated Services / Equipment: (✓ all that apply)

☐ Panel assessment ☐ Medication assistance ☐ AM care ☐ HS care ☐ Bath ☐ Toileting ☐ Lifeline
☐ Meal assistance ☐ Congregate meals ☐ Meals on wheels ☐ Respite ☐ Adult day program
☐ Equipment (circle) Wheelchair/Commode/Walker/Hospital bed/Mechanical lift ☐ SCHIPP equipment
☐ Oxygen Concentrator/Equipment

**Physician/Prescriber order required for the following in-home services:

☐ **Discharge Medication Plan and Prescription faxed to Home Care
☐ **Treatments (specify) _____
☐ **Wound care (specify) _____
☐ Other (specify) _____

COMMENTS: _____

_____

ANTICIPATED DISCHARGE DATE: _____ Date/Time of Fax: _____

Signature of Individual completing the referral: _____

For Home Care Coordinator Use: Date Received: _____

Date Care to start: _____ Referral faxed to ward ☐ Signature_____

GUIDELINES FOR USE:

Facility Home Care Referral

PURPOSE:

The Facility Home Care Referral form is:

- To be used by discharge coordinator and/or nursing staff
- To be used when home care is needed for a new or an existing client

PROCEDURE:

1) When home care is required for a new or existing client, the discharge coordinator and/or nurse will complete the Facility Home Care Referral from
2) Once complete, the form is faxed to the home care case coordinator
3) The Case Coordinator reviews the form, completes assessments, and creates the care plan.
4) The Case Coordinator will fax the referral back to the appropriate unit, with a signature, indicating the date and time care is to start.