

AT HOME CARE, Inc. : REFERRAL TO SERVICES

VERBAL SOC: ___/___/___ **Accepted by:** _____ **Actual/Confirmed SOC date:** ___/___/___ **by** _____ **LPN/ RN**
Referral Source: _____ (_____) _____
 (Name, Title) (Hospital/Facility) (phone/ pager #)
 Facility Admission: ___/___/___ Facility Discharge: ___/___/___
MO175 Patient Location 14-day prior to AHC SOC: Hosp. Cert.Rehab. Nsg. Home/ swing bed Home Other CHHA

PATIENT NAME: _____ **MSA: (Ots./Del)** is RURAL NY; **(HerK)** is Utica/Rome

HOME ADDRESS: _____ **PHONE:** (_____) _____
 Alternate Address (if different)/ POA/ Emerg. Contact/ other: _____ Date of Birth: ___/___/___

Social Security #: _____ **MEDICARE #:** _____ **NYS Medicaid #:** _____
 _____ **CWF verified & noted in BTI** **Medicaid active/ verified**

Other Insurance (specify) _____ **Contact:** _____ **Phone:** (____) _____
If MSP, does pt. qualify for Mcare covered svc.? Yes; No
 PRI Screen, Only (if not an active AHC patient, or billable to R-wood, \$ 135.00 due to AHC prior to release of screen to facility)

Physician #1 (485/Admit to Care): _____ **Other Involved Physician(s)/ cc 485 and/ or Follow-Up Community Orders:** _____
 _____ D/DO _____ MD/
 DO _____
 Address: _____ Address: _____
 Phone: (_____) _____ Phone:(_____) _____
 Complete Physician information in BTI? Courtesy Copy 485 to primary MD?

Follow Up MD Appointment on:

AHC SERVICES REQUESTED:	WOUND/OSTOMY MANAGEMENT:	HOME IV THERAPY: pre D/C teach? Y/ N
SN: _____	Wound Stage: _____	Pt. had the initial dose & no adverse effect? _____
PT:/ Pt. "PT only"? _____	C-WOCN consult indicated prior to D/C? _____	VAD type, length & insertion date: _____
Hha/ freq/ time: _____	AHC C-WOCN Consult Scheduled (QD or >)? _____	Medication, dose, "stop" date: _____
Other Svc: _____	RD indicated? _____ Weight _____ Labs obtained _____	Pt. teaching: able? Willing?: _____ Spec. Prec.? _____
Oxygen? _____ DME? _____	Comments: _____	Baseline Lab values obtained, & F/U orders: _____
Vendor & ph: _____	Supply Needs: _____	IV Pharm /Phone: _____ Pump? _____
All patients: _____	Allergies: _____	Weight: _____ Labs obtained: _____

DIAGNOSIS **ICD 9 Code- only authorized AHC personnel may code** **OTHER / SPECIAL INSTRUCTION(s):**

Diagnosis:	ICD9 Code:	Specialty Prescribed Diet:
_____	_____	_____
provisions: _____	Safety Concerns/	Other: _____
	_____	_____ Infusion pump/alarm _____ MOW
		_____ Lifeline _____ Other: _____
		_____ MRSA _____ Lives with _____
		_____ Sternal precautions
		_____ Lab orders: _____

PROCEDURES/ Date (procedure codes are NOT primary codes):
 PICC inserted on: _____ with X-ray verification of placement Assess for Telehealthcare Program (obtain parameters) Foley
 inserted on: _____ Assess for COPD Pathway
 Other procedures: _____ Assess for Falls Risk Program (PharmD consult)
 Assess for Palliative Care Program

Adm. by: _____ **Same Day/After Hrs/Next Day/ Approved Delay; Case Mgr. Assigned:** _____; **Mon. SNV by:** _____

If Patient referred for Physical Therapy services:

- Weight bearing status-circle (PWB; WBAT; FWB, Other: _____)
- ROM Orders-circle (PROM; AAROM; AROM; other: _____)
- Immobilizer/ brace orders
- Immobilizer/ brace orders
- PT Progress Notes requested
- OTHER: _____

Hip Precautions

PLAN:

1. Admission to AHC on ___/___/___ by _____ RN/ PT
2. **Special Instructions to AHC staff:**

OASIS NEEDED? ___Y/___N **FAX'ed to:** ___ by ___

Admit by: _____ Same Day/After Hrs/ Next Day; Delay to: _____ As auth by: _____; Case Mgr.: _____; Mon SNV by: _____

Adm. by: _____ Same Day/After Hrs/Next Day/ Approved Delay; Case Mgr. Assigned: _____; Mon. SNV by: _____