

INTAKE REFERRAL



Home Health Care Network

4002 Blalock Road, Houston, Texas 77080

Phone (713) 783-8049 ? Fax (713) 783-6941 ? 1-800-858-2889

Medical Record # _____

Admitting Nurse _____

DATE: _____ TIME: _____ TAKEN BY: _____

REFERRAL SOURCE: _____ PHONE #: () _____ - _____

PATIENT NAME: _____ M F DOB: _____
Last First Middle M/S/D/W/U

ADDRESS: _____
Street Apt # City State Zip Code

PHONE NUMBER () _____ - _____ ADMISSION DATE _____

DIAGNOSIS: _____

PATIENT LIVES WITH: _____
NAME, RELATIONSHIP AND TELEPHONE NUMBER

EMERGENCY CONTACT: _____
NAME, RELATIONSHIP AND TELEPHONE NUMBER

MEDICARE #: _____ - _____ - _____ SSN#: _____ - _____ - _____
VERIFIED _____ PRIOR EPISODE: _____

OTHER PAYER: _____
NAME, TELEPHONE AND CASE MANAGER NAME IF APPLICABLE

INSURANCE POLICY #: _____ GROUP #: _____

EMPLOYER : _____
NAME AND TELEPHONE NUMBER

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**ORDERS FOR HOME CARE**

SN  HCA  PT  OT  SLP  MSW

DME NEEDED: \_\_\_\_\_

PROVIDER IN THE HOME ?  YES  NO IF YES, HOW MANY DAYS, HOURS?

PHYSICIAN NAME: \_\_\_\_\_ PHONE #: ( ) \_\_\_\_\_ - \_\_\_\_\_

UPIN #: \_\_\_\_\_ FAX #: ( ) \_\_\_\_\_ - \_\_\_\_\_

PHYSICIAN NAME: \_\_\_\_\_ PHONE #: ( ) \_\_\_\_\_ - \_\_\_\_\_

UPIN #: \_\_\_\_\_ FAX #: ( ) \_\_\_\_\_ - \_\_\_\_\_

PT HOSPITALIZED?  YES  NO IF YES, WHERE: \_\_\_\_\_

PT LAST SEEN BY PHYSICIAN: \_\_\_\_\_

Key Map # \_\_\_\_\_  ADMIT  NON ADMIT REASON NON ADMIT: \_\_\_\_\_