

## DENVER HEALTH HOME HEALTH AGENCY REFERRAL

Name, MR #, Pat #, DOB

From: \_\_\_\_\_ UM RN  
 Phone/Pager # \_\_\_\_\_  
 Clinic: \_\_\_\_\_  
 Authorization #: \_\_\_\_\_  
 To: \_\_\_\_\_ (Agency)

**PATIENT'S ADDRESS, ZIP CODE, AND DIRECTIONS**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

PHONE COUNTY DOB MARITAL STATUS

**RELATIVE / CONTACT AND PHONE**

Social Security Number: \_\_\_\_\_  
 Medicare Number: \_\_\_\_\_  
 Medicaid Number: \_\_\_\_\_  
 Insurance Company & Number: \_\_\_\_\_  
 Self Pay: \_\_\_\_\_

Services (Please check)	Treatments and Frequency
PT	
OT	
Speech	
MSW	
RN	
Home Health Aide	
Special Equipment Needed	

Pharmacy:		
DME Company	Name, Contact and Phone #	
ADM. DATE	DISCH. DATE	DATE OF FIRST VISIT

**PHYSICIAN'S ORDERS AND PLANS FOR CONTINUING CARE**
**DIAGNOSIS, PROGNOSIS, AND REHABILITATION POTENTIAL**  
 (Primary, Secondary, include mental and social problems)

A. \_\_\_\_\_ C. \_\_\_\_\_  
 B. \_\_\_\_\_ D. \_\_\_\_\_

**MEDICATIONS INSTRUCTIONS AND PLAN OF CARE:**
**COMMUNICATION BARRIERS:**

FUNCTIONAL LIMITATIONS:	SUPPORTIVE DEVICES	ADVANCED DIRECTIVE: <input type="checkbox"/> Yes <input type="checkbox"/> No	NUTRITIONAL STATUS / DIET:
Psychological _____	<input type="checkbox"/> Eyeglasses	COR STATUS:	DRAW LABS:
Speech _____	<input type="checkbox"/> Hearing Aid		
Sight _____	<input type="checkbox"/> Dentures	ALLERGIES:	
A D L _____	<input type="checkbox"/> Braces	HT: _____	WT: _____
Hearing _____	<input type="checkbox"/> Casts		
Ambulation _____	<input type="checkbox"/> Crutches		

I CERTIFY THE PATIENT NEEDS:  Hospital Care  Residential Care  Skilled Care  Home Health Care  Intermediate Care \_\_\_\_\_

Follow-up Clinic: \_\_\_\_\_ Appt. Location: \_\_\_\_\_ Date: \_\_\_\_\_ (HHC) Homebound:  Yes  No

Referring Physician Pager Number

Attending Physician



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