

Patient Information

Patient's Last Name: _____ First Name: _____

DOB: _____ SSN#: _____ ID#: _____ Telephone #: _____

Service Address: _____

Bldg. #: _____ Apt #: _____ County: _____

City: _____ State: _____ ZIP: _____

Next of Kin: _____ Tele #: _____

Insurance: AmeriChoice BCBS/Health Options NHP Preferred Medical Plan United HealthCare Universal Other (Specify): _____Line of Business: Medicare (*Notice of Medicare Non-Coverage Must be Provided Upon Discharge by HHA*) Medicaid Commercial

Discharge Facility Name: _____ Discharge date: _____

Contact Person: _____ Telephone: _____ Fax: _____

 DME Name: _____ Tele #: _____ Pharmacy Name: _____ Tele#: _____**Ordering Physician and PCP Information**

Referring Physician Name: _____

Telephone#: _____ Fax #: _____

Address: _____ City/State/ZIP: _____

Primary Care Physician Name: _____ Telephone#: _____

Clinical Information

Primary Dx Code/Description: _____

Secondary Dx Code/Description: _____

Allergies: _____ Height: _____ Weight: _____

 HHS: R.N. Eval. P.T. Eval. S.T. Eval. O.T. Eval. M.S.W. H.H.A. Sk.Nurse Hi Tech

Orders: _____ Frequency: _____ Duration: _____

 Wound Care: Location _____ Dimensions: _____ cm x _____ cm x _____ cm

Start of Care Date: _____ Orders: _____ Frequency: _____ Duration: _____

 Wound Care: Location _____ Dimensions: _____ cm x _____ cm x _____ cm

Orders: _____ Frequency: _____ Duration: _____

 Medication: _____ Dose: _____ Route: IV: _____ SQ: _____ IM: _____

Frequency _____ Duration: _____ Time/Date Next Dose Due: _____

(First Dose must be administered prior to ordering Home Health Care) Medication: _____ Dose: _____ Route: IV: _____ SQ: _____ IM: _____

Frequency _____ Duration: _____ Time/Date Next Dose Due: _____

(First Dose must be administered prior to ordering Home Health Care) Lab Test(s): _____ Dates: _____*(Lab tests performed during regular business hours)* Other Services: _____ Other Pertinent Clinical Information/ Medical Justification (Comments): _____**EMP Network Provider Information**

Provider Name: _____ Contact Person: _____ Fax#: _____

EMP Case Coordinator/Manager (Name / Signature)

Date