

# HOME HEALTH EVALUATION & STATUS REPORT

Agency: \_\_\_\_\_ Date: \_\_\_\_\_ SOC: \_\_\_\_\_

Patient's Last Name: \_\_\_\_\_

First Name: \_\_\_\_\_

Health Plan: \_\_\_\_\_

County: \_\_\_\_\_

DOB: \_\_\_\_\_

SSN#: \_\_\_\_\_

Telephone #: \_\_\_\_\_

Month      Date      Year

ICD-9Codes

Primary Diagnosis:						
Secondary Diagnosis:						

Description of Patient Illness: \_\_\_\_\_

Vital Signs:      Temp: AP (Reg/Irr) \_\_\_\_\_      RP (Reg/Irr) \_\_\_\_\_      Resp: \_\_\_\_\_      BP: \_\_\_\_\_

Homebound  No  Yes      Describe Reason: \_\_\_\_\_

Home Environment:       Lives Alone     Debilitated     Frail Elderly Caregiver     Other: \_\_\_\_\_

Teaching and training of patient/caregiver:     Possible     Not Possible

**Wound Care:**

TYPE	LOCATION	DIMENSIONS	DRAINAGE	STAGE	Improving
		L _____ cm. x W _____ cm. x D _____ cm.			
		L _____ cm. x W _____ cm. x D _____ cm.			
		L _____ cm. x W _____ cm. x D _____ cm.			

*(Agency please submit a status report on all wound care cases on a weekly basis)*

Physician been notified of Plan of Care:  Yes     No      Next Physician Appointment Date: \_\_\_\_\_

Medications being administered by Nurse:  Yes     No      Indicate Medication: \_\_\_\_\_

AGENCY RECOMMENDATIONS/REQUEST				NETWORK OFFICE USE ONLY			
Discipline	# Visits	From	To	Discipline	# Visits	From	To
Specify Reason for Follow-up Visits/Plan of Care/Frequency <i>(Please be specific and attach any supporting documentation):</i> _____ _____ _____ _____ Name: _____ Signature: _____ Date: _____      Time: _____				Comments: _____ _____ _____ _____ Name: _____ Signature: _____ Date: _____      Time: _____			

*\*Authorizations are usually provided to cover 2 weeks of care at which time a Recommendation and Status Report Form must be submitted for review if recommendation is for services to be continued.*