Home Care Wellness
Referral Worksheet

Phone: 313-586-4111 Fax: 313-556-2225

REFERRAL DATE _____
SOC DATE _____

PATIENT NAME _____
LAST FIRST MI

ADDRESS _____
_____
_____

HOME PHONE _____

CONTACT OUTSIDE OF HOME:
_____

PHONE# _____

PATIENT DOB: _____

MEDICARE # _____

BCBSM # _____

OTHER _____

FOLLOWING PHYSICIAN: _____
NPI _____

ADDRESS _____
_____
_____

PHONE _____
FAX _____

REFERRING PHYSICIAN: _____

NPI _____

PHONE _____

MR# _____ (DO NOT FILL)

☐ RN ☐ PT ☐ OT ☐ ST ☐ AIDE ☐ MSW

***** ☐ *I Certify that the above patient is under my care and that I have had a F2F encounter with the above patient on _____ (Date)*

* DIAGNOSIS & REASON FOR PATIENTS LAST VISIT:
_____
_____
_____
_____

* HOMEBOUND REASON:
_____
_____
_____
_____
_____

* IMPORTANT CLINICAL FINDINGS @ F2F ENCOUNTER:
_____
_____
_____
_____
_____

*** Physician's Signature** _____

*** Date** _____

- If patient has diabetes, then feet & lower extremities will be monitored for lesions & patient/caregiver will be educated on proper foot care.
- If patient has a risk for falls, then falls will be assessed & patient/caregiver will be educated on interventions to prevent falls.
- If patient has depression, interventions will occur such as medication review, referral for other treatment, or a monitoring plan for current treatment.
- If patient has pain, then pain will be assessed & patient/caregiver will be educated on interventions to mitigate pain.
- If patient has a risk of pressure ulcers, then skin will be assessed & patient/caregiver will be educated on pressure relief measures.

Additional Comments - _____
_____
_____

ITEMS WITH * MUST BE FILLED OUT BY A PHYSICIAN, PHYSICIAN ASSISTANT OR NURSE PRACTITIONER