Universal in Home Health Care

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REQUEST FOR SERVICE/ MEDICAL VERBAL ORDERS/CPC

CLIENT NAME:	**REFERRAL DATE** REQUESTED SOC DATE
ADDRESS:	REFERRAL SOURCE PHONE
PHONE NO:	□ EMERG. CONTACT □ RELATIVE □ SIGNIF. OTHER □ CAREGIVER
DOB: **SEX:** □ MALE □ FEMALE	NAME: ADDRESS PHONE #
MARITAL STATUS: □ S □ M □ D □ SEP □ W	D/C FROM HOSPITAL □ SNF/REHAB FACILITY □
MEDICARE ID:	DATE ADM D/C
MEDICAID ID #:	OTHER INSURANCE: PHONE #:
DIAGNOSIS: (List Primary Diagnosis First) DATE: 1) _____ 2)_____ 3) _____ 4)_____	SURGERY DATE(S): **ALLERGIES** **LAST SEEN BY MD:** BRIEF MEDICAL HISTORY:
HME/SUPPLIES	**DIET**

VERBAL ORDERS / HOME HEALTH PLAN:
DISCIPLINE: FREQUENCY/DURATION (if requested)

SKILLED NURSE	_____	HOME HEALTH AIDE	_____
PHYSICAL THERAPIST	_____	SOCIAL WORK	_____
OCCUPATIONAL THERAPIST	_____	SPEECH LANGUAGE PATHOLOGY	_____

HOME BOUND REASRON:_____

MEDICATIONS: PLEASE ATTATCH PATIENT'S MEDICATIONS LIST

WOUND CARE: _____
WOUND CARE SUPPLIES:_____

_____

PHYSICIAN NAME:	**PHYSICIAN SIGNATURE:**

STAFF SIGNATURE/TITLE: _____ **DATE:** _____

I hereby Certify that the above patient is under my care and requires the above home care services because he/she is confined to the home. These professional services are to be provided on an intermittent basis and the established plan contained in the record will be reviewed by me at least every two months. These services are needed to treat the condition for which the patient was treated during the related inpatient or post hospital extended care facility approved stay.