Fax: 920.966.0334 Phone: 920.237.6242

Evergreen At Home-Home Health Referral Form

Date of Referral:		Name Referring:		Phone:	

Referred Patient Information

Anticipated Date of Discharge from facility:			
Patient Name:		Patient SS#:	
Address/Service Location:		City:	
		☐Male ☐Female	
Zip:		County:	DOB:
Pharmacy:			
Living Situation:	☐Alone ☐Spouse ☐Friend ☐Family ☐Other (CBRF, RCAC):		
Emergency Contact:		Relationship:	
Emergency Contact Number:			

INSURANCE INFORMATION

Medicare#:		Medicaid#:	
Private/Medicare Replacement Insurance:			
☐Network Health Plan	☐BC&BS	☐Tri-Care	☐Other:
Provide copy of Cards			

Home Care Services:	☐ Skilled Nursing	☐ Physical Therapy Eval and Tx	☐ Occupational Therapy Eval and Tx
☐ Admit to Home Health	☐ Speech Therapy Eval and Tx	☐ Medical Social Worker Eval and Tx	☐ Home Health Aide

Medical and Social History

Primary Dx and Surgical Procedure Information:	
Ambulation Status:	☐ IND w/assistive device ☐ W/C bound ☐ IND w/o Assistive Device
Therapy Home Evaluation completed:	☐Yes ☐ No If yes: Attach copy
Current Wound Care Tx:	

Anticoagulation Mgmt:	Physician Ordering Coumadin/Warfarin Dosing	Next Scheduled Pt/INR:
☐Yes ☐No		
Current Coumadin Dose:		
Other upcoming scheduled lab work:		

Physician Signature:		Date:	
Physician Print Name:		Fax:	

Please call 920.237.6242 to confirm referral received. Thank you. Please fax additional pertinent information if available, face sheet, H &P, D/C Summary, Orders, Therapy Notes, etc…

For Office Use Only		
Entered in Axxess	Authorization Completed (if required)	Admit Date Scheduled with Patient
Date/Initial	Date/Initial	Date/Time/Initial