VISITING NURSE SERVICE
OF ITHACA AND TOMPKINS COUNTY

PATIENT REFERRAL FORM

TO MAKE A PHONE REFERRAL **607.273.0466**

TO FAX A REFERRAL **607.216.9429**

REQUESTED START OF CARE DATE:_____

PHYSICIAN SIGNING HOME CARE ORDERS

PHYSICIAN NAME

ADDRESS

CITY STATE ZIP

TELEPHONE # ( )

FAX # ( )

NPI #

LICENSE #

OFFICE CONTACT TELEPHONE #

PHYSICIAN SIGNATURE DATE

PATIENT INFORMATION

LAST NAME FIRST NAME

SEX ☐ Male ☐ Female

TELEPHONE #1 TELEPHONE #2

SERVICE ADDRESS APT/BLDG#

CITY STATE ZIP

DATE OF BIRTH

SOCIAL SECURITY #

LANGUAGE SPOKEN BY PATIENT

MENTAL HEALTH STATUS: ☐ Oriented ☐ Forgetful ☐ Confused

Is the patient self-directing? ☐ Yes ☐ No

LIVES WITH ☐ Caregiver ☐ Family ☐ Alone

EMERGENCY CONTACT / RELATIONSHIP

CONTACT TELEPHONE #

Day Evening

INSURANCE INFORMATION

MEDICARE #

MEDICAID #

COMMERCIAL INSURANCE CARRIER (NAME & AUTHORIZATION #)

SUBSCRIBER

POLICY #

GROUP #

CASE MANAGER @ PAYOR

SECONDARY INSURANCE INFORMATION

COMMERCIAL INSURANCE CARRIER (NAME & AUTHORIZATION #)

SUBSCRIBER POLICY # GROUP #

REASON FOR HOME CARE/MD ORDERS

HOME CARE DIAGNOSIS:

1. _____
2. _____
3. _____

PMH: _____

ALLERGIES: _____

DIETARY RESTRICTIONS: _____

IS THE PATIENT HOMEBOUND? ☐ YES ☐ NO

MEDICATIONS / DOSE / FREQUENCY / ROUTE: ☐ Meds list attached

_____

_____

_____

_____

_____

DIABETES: ☐ **TYPE 1** ☐ **TYPE 2** ☐ **GESTATIONAL**

☐ Teach diabetic management/self care ☐ Teach glucose monitoring

☐ Contact MD if blood glucose is above _____ or below _____

☐ Current HbA1c _____ Current gluclose _____

Glucometer and supplies in home? ☐ YES ☐ NO

CARDIOVASCULAR DISORDERS:

☐ Educate on signs and symptoms of: CHF, MI, CAD, A.Fib, HTN

☐ Assess cardiac status ☐ Daily weight recording ☐ Current weight_____

☐ Contact MD for BP systolic above _____ or below _____

diastolic above _____ or below _____

☐ Apical pulse above _____ or below _____

WOUNDS:

☐ 24-hour supplies or prescription given

☐ Neurogenic ☐ Pressure ☐ Venous ☐ Arterial

☐ Location _____

☐ Stage & size of wound _____

☐ Hydrogel ☐ Ca-Alginate ☐ Hydrocolloid ☐ NS wet to damp

☐ Other _____

☐ Irrigate ☐ Cleanse ☐ Solution _____

☐ 3-5 wk ☐ 1-2 wk ☐ Daily ☐ Other _____

MEDICATIONS / DIET CHANGES: ☐ Teach nutrition

☐ Teach medication and adherence with new/old regimens

ASTHMA / COPD: ☐ Assess home for triggers

☐ Educate on disease management ☐ Peak Flow Meter

☐ Educate on use of nebulizers/inhalers ☐ Educate O_2 precautions

GAIT / AMBULATORY STATUS: ☐ Unassisted

☐ Bedbound ☐ Assistive device _____

☐ Evaluate home safety ☐ Assess equipment needs ☐ Yes

☐ Weight-bearing status _____

Did patient have a Rehab Hospital/Unit admission within the last 10 days? ☐ No

SKILLED SERVICES: Frequency: _____ times per week for _____ weeks

☐ RN ☐ PT ☐ OT ☐ ST ☐ MSW ☐ HHA

ADDITIONAL INFORMATION:

_____

_____

_____

_____