

VNA INTAKE REFERRAL FORM

FOR SKILLED NURSING FACILITIES

Items faxed with this referral (check all that apply):

- | | |
|---|--|
| <input type="checkbox"/> Demographics / insurance information | <input type="checkbox"/> Problem list |
| <input type="checkbox"/> Advance directives | <input type="checkbox"/> Nursing home discharge summary |
| <input type="checkbox"/> Latest hospital discharge summary | <input type="checkbox"/> List of meds client will be discharged on |

Referral Date	Name of person making referral	Phone number of person making referral
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MD who will sign home care orders _____
 Other MD's following patient: _____

Patient Name	DOB	Does the client have a specific need for visit day after d/c? <input type="checkbox"/> dressing change <input type="checkbox"/> safety issues <input type="checkbox"/> lab draw <input type="checkbox"/> _____ If not, we will call them on day after d/c to set up visit
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- Visit patient at the address on demographics sheet **If not, list visit address & phone number below.**
 Current contact person is listed on demographic sheet. **If not, list contact person below.**
 Insurance information is listed on demographic sheet. **If not, list insurance information below.**

Visit Address	Apt Number	City/Town	Zip Code	Visit address phone Home: Cell:
Contact Person (if different than demographic sheet)			Relationship	Home #: Work #: Cell #:

Insurance: Primary _____ ID# _____
 Other: _____ ID# _____

Code Status: Full code DNR / DNI See attached directive Other:
 UTI in last 14 days? Yes No

Recent Inpatient Stay? Name of facility	Admission Date	Discharge Date
1. _____	1. _____	1. _____
2. _____	2. _____	2. _____

All SNF days were billed to Medicare
 Other: _____

List any ED visit dates / Outpt procedure dates

Client can sign consent **OR** Consent to be signed by Relative Power of Attorney / Guardian
 Name: _____ Relationship: _____
 Address: _____ Phone: _____

PRIMARY DIAGNOSIS FOR REFERRAL: _____

ALLERGIES / REACTION: _____

SERVICES NEEDED:

- | | | |
|--|--|--|
| SN <input type="checkbox"/> Cardiopulm assessment
<input type="checkbox"/> Med check
<input type="checkbox"/> Wound assess / dsg change
<input type="checkbox"/> Evaluate home situation
<input type="checkbox"/> Other: | PT: <input type="checkbox"/> Home safety eval
<input type="checkbox"/> Assess strength /balance /endurance
<input type="checkbox"/> Assess mobility / gait
<input type="checkbox"/> Assess need for adaptive equipment
<input type="checkbox"/> Other: | OT: <input type="checkbox"/> Assess bathroom safety
<input type="checkbox"/> Assess tub / toilet transfers
<input type="checkbox"/> Assess ability to complete ADL's
<input type="checkbox"/> Assess need for adaptive equipment
<input type="checkbox"/> Other: |
|--|--|--|

OTHER: (SPECIFY): MSW LNA Private Duty Other:

CLINICAL REPORT

PATIENT NAME:

DOB:

Mobility: Ambulates Wheelchair Bedbound
 Ambulation: Without devices Walker Other device: _____
 Amb Assist: No assist With ___ assist
 Transfers: Indep With ___ assist Mechanical lift: _____
 Other info:

Self care: Indep Assisted Dependent

Cardiac/Resp: No Problem On home O2 / Vendor: _____
 Describe problems: _____

Diet: _____ Appetite: Good Fair Poor
 Describe problems: _____

Skin: Intact At risk due to: _____
 Open areas

Location: _____	Location: _____
Size: _____	Size: _____
Depth: _____	Depth: _____
Drainage: _____	Drainage: _____
Dressing change routine: _____	Dressing change routine: _____

Bladder: Voiding Foley Other: _____
 Continent Incontinent Other: _____

Bowels: Continent Incontinent Last BM: _____

Impairments: vision _____
 hearing _____
 communication _____
 cognition _____
 other _____

Living situation:

If med list is not attached, please list discharge meds here: