



VNA Home Care Services Referral Form

1110 Prim Road, Colchester, VT 05446 www.vnaces.org
Intake Phone: 802-860-4400 (Toll Free) 800-427-1908 (FAX) 802-860-4464

1. Please indicate your patient's home care needs on the checklist below
2. VNA to access all patient demographics, notes, and information from FAHC EPIC/PRISM **OR**
 Patient information not in PRISM – see faxed or attached demographics, insurance information, current medication and problem list, and notes from last/pertinent office visit, phone encounter or inpatient stay
3. Submit referral one of the following ways:
 - On secure VNA website www.vnaces.org Fax to (802) 860-4464
 - E-mail to Intake Dept. at nurse@vnaces.org Call to Intake Dept. at 860-4400

Thank you for referring your patient to the VNA!

Date: _____ **Patient name:** _____ **Date of Birth:** _____

Name of referring facility, physician, or other source: _____

MD who will sign VNA home care plan and orders: _____

Contact or Power of Attorney if patient is cognitively impaired: _____

Who should we call for questions about this referral? _____ Phone/Ext: _____

Inpatient admission date: _____ Inpatient discharge date: _____

Requested VNA start of care date: _____

Please check any of the VNA services that apply:

- Medication management and instruction:**
 - Recent medication changes New medication Multiple medications Injectable medications
 - Patient or caregiver confused about medications or schedule
 - Patient needs evaluation of unexpected symptoms possibly related to medication
- Disease management** (Nursing assessment, education, treatment):
 - Hypertension or abnormal blood pressure CAD
 - Heart Failure COPD
 - Diabetes Arthritis
 - CVA Cancer
 - Other Neuro/Rehab: **Neuro Rehab Nurse** evaluation
 - Wound care: Pressure ulcers Vascular ulcers Post surgical wound Other
 - Ostomy/incontinence **Certified Wound Ostomy Continence Nurse** assessment
 - IV Therapy** (please call Intake to discuss needs and administration schedule)
 - Cognitive/Dementia/Mental Health
 - Safety issues: needs prompt home assessment visit **Mental Health Nurse** evaluation
 - Family concerns/Respite needs
 - Other: _____
 - Lab work: _____
 - Needs personal care/hygiene and bathing assistance (**LNA**)
- Assessment of care needs:**
 - Recent decline in functional ability Pt. or family concerned about managing at home
 - Multiple hospitalizations/ED visits/frequent office visits Assess Choices for Care
 - MSW:** Need for long-term planning or different living situation Discuss Advance Directives
- Rehabilitation and therapies** (PT, OT, Speech):
 - Recent falls
 - Physical therapy**
 - Mobility/gait assessment and training Strength training /exercise program
 - Post surgical assessment and treatment Home safety evaluation
 - Assess needs for home equipment/adaptive devices
 - Occupational Therapy:** _____
 - Speech Therapy:** _____
- End-of-Life Care:** Palliative Care Hospice Care Vermont Respite House Pt. aware of prognosis
 Contact: _____ Phone: _____
- Private Care/Shift Care/Homemaking:** Contact: _____ Phone: _____ to discuss needs
- Adult Day Program:** Contact: _____ Phone: _____ to arrange tour of sites