Referrals may be phoned in to Intake at (203) 782-3192 or Faxed at (203) 562-4276 * Note: Faxed referrals received after normal business hours weekdays 8:30 a.m. to 4:30p.m. will be attended to the next business day

CONTINUUM HOME HEALTH
REFERRAL FORM FOR HOME CARE SERVICE

Referral Date ____/____/____ Date Home Care to Start ___/____/____ Referral Source_____

Referral Source Contact Person_____ **Phone no.**_____

Reason for Referral:_____

Patient Name_____**Telephone**_____

Address (include apt #) _____

Soc Sec#_____-_____-_____ **DOB**_____/_____/_____ **Gender: ☐Male ☐Female Language:**_____

☐Medicaid No._____ **☐Medicare No.** _____

Other Insurance Name_____**No.**_____

Emergency Contact/Relationship to Patient:	**Primary Physician/Phone#**
Home Phone: Work Phone:	**Secondary Physician/Phone#**
Clinician/Phone# :	**CONSERVED ☐ FINANCIAL ☐ MEDICAL ☐ BOTH ☐**

HOSPITALIZATION (if applicable) ADM DATE:_____ **DISCHARGE DATE:**_____

Diagnoses: _____

Allergies: _____ **Pharmacy:** _____ **Phone No.**_____

Medication List:

_____

_____

_____

_____

MEDICATIONS PHONED INTO PHARMACY ☐ YES ☐ NO

REFERRAL SOURCE SIGNATURE _____ **DATE:** _____

Medical Orders:

☐Nursing: ☐ 10-14 x wk x 60 days ☐5-7 x wk x 60 days ☐ Other Frequency_____

☐PRN for skilled assessment or medication administration as needed

☐Supervise / Administer medications to patient per Medication List below ☐Prefill Medbox and monitor compliance

☐Other: _____

Other Services: ☐PT ☐OT ☐ST ☐HHA ☐MSW (note Medicaid does not pay for MSW)

Goal: ☐Client will achieve maximum level of functioning and will be able to live safely in the community.

MD SIGNATURE: _____ **Date:**_____

Patient Name_____

Other Information/Special Instructions/Directions/Additional Meds: _____