BLUESUMMIT

Referral Intake Sheet:

ProCare ☐ Shenandoah ☐
Seven Hills ☐ Reliable ☐
NOVA ☐

Phone Number : (434) 847 – 6400
Fax Number : (434) 847 - 2674
Email : referral@bluesummitcare.com

Referral Source Name: _____
Who sent the referral: _____
Referral Date: _____

Referral is: ◯ **Home Healthcare** , ◯ **Home Care** or ◯ **Hospice** Admission Date: _____
Referral is : ◯ Institutional or ◯ Community

Patient Name: **Last** _____ **First** _____ **Middle Initial** _____

SS # _____ **DOB:** _____ ◉ **M** or **F** ◯

Address : _____ City: _____ ZIP: _____

Home Phone: _____ Cell Phone: _____

Emergency Contact: _____ Relationship to Patient: _____

Phone Number: _____ **Auth #:** _____

INSURANCE TYPE: _____ **Policy Number**: _____

PCP: Dr. _____ Phone: _____ Fax: _____

When was the last Patient visit to this Doctor? _____

Patient needs: Assess and Evaluate ☐ SN ☐ PT ☐ OT ☐ ST ☐ Medications ☐ Consultation ☐ MSW
OTHER: _____

Health & Physical: ⊙ **Y** or **N** ◯
Face To Face encounter: ◯ **Y** or ⊙ **N**
Orders: ◯ **Y** or ⊙ **N** if not **Orders are**: _____

Clinical Findings that support the need for Services: (Signs and Symptoms of the medical conditions supporting the need for Home Health services)

_____

_____

Home Bound Status: (Describe the clinical and/ or physical findings showing functional limitations that result in the patients' normal inability to leave or be away from their home and qualify for Home Healthcare)

_____

_____

_____