Vancouver Home Health Care Agency

Referral Information

Date of Intake: _____ SOC Date: _____ EOC Date: _____
Patient Status: ☐ New ☐ Re-admit
Referral Taken by: _____ Referring Individual: _____
Referring Organization: _____ Time: _____
Admit RN/PT _____ Case Manager: _____

Patient Information

Last Name: _____ First: _____ MI: _____
Address: _____ City _____ Zip: _____
DOB: _____ Age: _____ ☐ Male ☐ Female Ethnicity: _____
Social Security No.: _____ Home Phone: _____
Emergency Contact Name: _____ Contact Phone: _____
Relationship: _____ Alternate Phone: _____
Emergency Contact Address: _____

Physician Information

Referring Physician: _____ Phone: _____ Fax: _____
Referring Physician's Address: _____
Attending Physician: _____ Phone: _____ Fax: _____
Attending Physician's Address: _____
Orders Received? ☐ Yes ☐ No Orders Faxed? ☐ Yes ☐ No
Diagnosis: 1. _____ ICD9 Code: _____
2. _____ ICD9Code: _____
3. _____ ICD9 Code: _____
Disciplines Ordered: ☐ SN ☐ PT* ☐ OT ☐ ST ☐ HHA ☐ MSW**
*PT Notified? ☐ Yes ☐ No Date: _____ Name: _____
**MSW Notified? ☐ Yes ☐ No Date: _____ Name: _____

Pay Source

Medicaid No: _____
Private Insurance Co: _____ Phone: _____
Contact Person: _____

RN Signature: _____ Date: _____