CAYUGA COUNTY HOME CARE AGENCY
8 Dill Street Auburn, NY 13021
Tele: 315-253-1301 Fax: 315-253-1465

REFERRAL INFORMATION

Case Manager Assigned:		
Team:		
District:	**New Pt:**	**ROC:**

DEMOGRAPHIC INFORMATION

Patient's Name *Last* *First* *MI*

Patient's Address:
Street _____

City State Zip **Phone Number :**

Visit Name:_____

Address: Street:_____

City *State* *Zip* **Phone Number :**

Date of Birth : *Month* *Day* *Year*
___ ___/ ___ ___/ ___ ___ ___ ___

Social Security #:
__ __ __ - __ __ - __ __ __ __

Gender: Male Female

Emergency Contact & Telephone:

Insurance: ***(Attach Ins. Verification)***

Insurance ID #:

Medicare #:

Medicaid #:

1) Physician
Name: _____

Address: _____

Telephone #: _____

Fax #: _____

2) Physician
Name: _____

Address: _____

Telephone #: _____

Fax #: _____

DIAGNOSES/SURGERY:	**Onset Date**	**ICD –9-Codes**

Past Medical History:

Orders:

REFERRAL STATUS

Admitted
SOC Date:

Priority Ranking:
1 Nurse Visit 2- Aide Visit
3-TC 4-Deferred Visit

Eval Not Admitted

Not Homebound (HHABN)
Not Skilled/Medically Nec.(HHABN)
Not Safe (screen completed)
Requires Higher Level of Care
Other

Not Taken Up
Not found
Refused care
Hospitalized
Other

Dependent on Electric Service? **Yes** **No**
Risk for Hospitalization? **High** **Low**

Emergency Contact:

Contact Telephone #:

REFERRAL SOURCE:

NEED LAST HOSPITALIZATION DATES:
Hospital/SNF: _____

Hospitalized: From ___/___/_____ **To:**___/___/_____

Rehab/SNF: From ___/___/ ____ **To:** ___/___/_____

MD office: _____ **last app't**_____
Contact person:
_____

Phone Number: _____
Verbal Order: **Yes** **No**

Services Requested:

SN **HHA** **PT** **OT** **SLP**

MSW **RD** **RT** **Evaluate for: HHA / PT**

PATIENT STATUS:

Height: **Weight:** **Mental Status:**

VS:

Allergies :

Activity Restrictions:

Weight Bearing Status:

Equipment / Device:
Parameter for use:

Diet:

Taken By: _____ **Referral Date:** _____ **First Visit:** _____ **Beeper Nurse copy**

Referral processed by Secretary (Initial) :_____ **Date :**_____