



Health Management, Inc.
 6856 Eastern Avenue NW Suite 376
 Washington, DC 20012
 Tel (202) 829-1111
 Fax (202) 829-9192

Referral for Home Health Services
 Mcare SKN _____ PCA _____ Mcaid _____
 RN Assigned _____ Referral Date _____
 SOC _____

1. Patient Name: _____
 Address: _____
 (Including Zip) _____
 Temp Address: _____
 (Including Zip) _____
 Phone: _____
 Known to HMI: _____
 SS#: _____ DOB: _____ Age: _____ Sex: _____ Ht: _____
 Wt: _____ Marital Status: S () M () W () D () Race _____
 Allergies _____
 Responsible Care Giver/Significant Other/Emergency Contact
 (Friend, Neighbor, Relative, etc.): _____ Relationship: _____
 Address: _____
 Phone: Home: _____ Work: _____
 Mental Status: _____
 Living Arrangements: _____

3. Insurance Info: _____ Insured Name: _____
 Medicare: _____ Other: _____
 Medicaid: _____ Eligible: _____

4. Diagnosis: _____ ICD9 _____ Date Onset Evaluate/Exacerbation _____
 Primary: _____
 Secondary: _____
 Surgical Procedure: _____
 Pertinent Medical Info: _____

 Medications: _____

 Diet: _____ Treatment / Lab: _____
 Wound Care Orders: _____ Equipment at Home: _____

5. Other Companies in Home: _____

6. Physician Responsible for Md F/U: _____ Phone: _____
 Physician Giving Orders: _____ Phone: _____

7. RN receiving orders: _____ Licensed checked: _____

8. Services ordered:
 Personal Care Aide ___ Home Health Aide ___ Skilled Nursing ___ Physical Therapy ___
 (Reason/Need) _____ (Reason/Need) _____
 Occup. Therapy ___ Speech Therapy ___ Social Worker ___ Nutrition Therapy ___
 (Reason/Need) _____ (Reason/Need) _____ (Reason/Need) _____ (Reason/Need) _____



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CONFIDENTIAL FAX COVER SHEET

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