REFERRAL FAX

FAXING TO: Seasons HomeCare Warsaw, IN	**574-268-2268**
SENDER COMPANY/ Organization	
CONTACT NAME:	
CONTACT PHONE:	
SENDING TO Seasons Contact	
NUMBER OF PAGES:	

COMMENTS:

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1101 Husky Trail
Warsaw IN 46582
Phone: 574/298-9000
Fax: 574-268-2268

Home Care Service Request
REFERRAL AUTHORIZATION FOR PLAN OF CARE

Referring Agency:	Requested SOC Date:

PATIENT DEMOGRAPHICS

Patient's Name (Last, First)			
Patient's Address			
Patient's Phone:	(H)	(W)	(C)

Age:	Social Security #	Lives With:

Facility Admit Date:	Facility Discharge Date:

EMERGENCY CONTACTS

Name:	
Address:	
Phone: (H)	(C)
Relationship:	Keys: ☐Yes ☐ No

Name:	
Address:	
Phone: (H)	(C)
Relationship:	Keys: ☐Yes ☐ No

MEDICAL INFORMATION

Primary Physician:		
Address:		Phone #
License #	UPIN:	Record #
Primary Diagnosis:		Date:
Surgical Procedures:		Date:
Prognosis: ☐ Good ☐Fair ☐Poor Comment:		

Reason for Hospitalization: *(Please include chief complaint, brief medical history, and treatments received)*

Social Assessment/Support System *(Please include safety and environmental concerns, pets, etc.)*

MEDICATIONS:				ALLERGIES:
Name	Dose	Frequency	Route	VITAL SIGN RANGE
				BP PULSE TEMP
				HT WEIGHT RESP
				PAIN (0-10 SCALE)
				PARAMETERS TO CALL MD:
				BP< ___________>_________________
				GLUCOSE >___________>____________
				COGNITIVE:

FUNCTIONAL LIMITATIONS: ☐ Amputation ☐ Paralysis ☐ Legally Blind ☐ Bowel/Bladder ☐ Hearing ☐ Speech ☐ Endurance ☐ Dyspnea with minimal exertion	DIET/NUTRITIONAL REQUIREMENTS:
ACTIVITIES PERMITTED:	

TYPE OF SERVICE RECOMMENDED:

In-Home Care Services ☐ADLs ☐Meal Prep ☐Homemaking ☐Laundry ☐Range of Motion Exercises ☐ Incidental Transportation (grocery, MD, Rx) ☐Medication Reminders ☐Meaningful Activities

Residential Care Home ☐ADLs ☐Meal Prep ☐Homemaking ☐Laundry ☐Range of Motion Exercises ☐ Incidental Transportation (grocery, MD, Rx) ☐Medication Reminders ☐Meaningful Activities

Adult Day Services ☐ADLs ☐Meals ☐Range of Motion Exercises ☐Meaningful Activities ☐Medication Reminders

Referral Initiated by (Print name and title):		
Phone/Pager:		Date:
MD Signing POC:	Phone/Pager:	Date:
Print MD Name:	Licence #:	UPIN#

Thank you for your referral!

Seasons HomeCare will contact you immediately after receiving this fax.

If you do not receive a call from Seasons HomeCare within 15 minutes after faxing this form, please call our office immediately at 574/298-9000.