HOME HEALTH FAX
614-840-2800

OhioHealth

Referral Phone: 614-566-0888

PATIENT INFORMATION			
Patient's Name:			Date:
Address:			City, State, Zip:
Home Phone:			Cell Phone:
SS#:			DOB:
Medicare #:			Mcd#:
Insurance:	Policy #:		Group:
Secondary Contact:	Relationship:		Phone:

Please fax patient demographic sheet or complete information above

Patient Diagnosis: _____ Allergies: _____

Ordering Physician: _____ Phone: _____

Office Contact: _____ Hx of: ☐ CHF ☐ Diabetes ☐ Pressure ulcer

Has pt received influenza vaccine? ☐ Yes ☐ No Has pt received pneumococcal vaccine? ☐ Yes ☐ No

❑ Only complete if patient will be going to DIFFERENT address other than their own:

Name: _____ Relation: _____

Address: _____ Phone: _____

SERVICES REQUESTED

Home Health Skilled Services:

- ❑ RN – Skilled Nursing
- ❑ PT –Physical Therapy
- ❑ SLP- Speech/Language Pathology Therapy

Home Health Services Below – must be secondary to above

- ❑ OT – Occupational Therapy
- ❑ MSW – Social Services
- ❑ HHA-Home Health Aide

Height: _____ Weight: _____

Infusion or Enteral Therapy Information:

Is the first dose being administered in the home? ❑ Yes ❑ No

Next dose date/time: _____

❑ Enteral Route: ❑ Bolus ❑ Pump

Pharmacy Information:

Please specify supplying pharmacy: _____

Anaphylactic kit ordered-type: _____

Venus Access Device:

- ❑ PICC Line Type:
- ❑ Peripheral
- ❑ Tunneled CVC Type: _____
- ❑ Acute/Temporary CVC
- ❑ InfusaPort Will InfusaPort need to be accessed for homecare needs? ❑ Yes ❑ No
- ❑ Other _____

Date Inserted: _____

Physician Signature: _____ Date: _____

❑ Please indicate if you would like a call to confirm that the fax was received