JEFFERSON COUNTY PUBLIC HEALTH SERVICE REFERRAL FORM

Projected SOC Date: _____ Primary Nurse: _____
Admitting Nurse: _____

PATIENT INFORMATION

Patient: _____ Birthdate: _____ SS#: _____
Address: _____ Phone #: _____
_____
Admit Date: _____ Discharge Date: _____ Allergies: _____
Discharge to: ☐ Home Alone ☐ Home with Family ☐ Different Address: _____

INSURANCE INFORMATION

1. _____ Policy # _____
2. _____ Policy # _____

PHYSICIAN INFORMATION

Primary Care Physician: _____ Signing POC Physician: _____
Address: _____ Address: _____
_____ _____
Phone #: _____ Phone #: _____

NOK Name: _____ Emergency Contact Name: _____
Address: _____ Address: _____
_____ _____
Phone #: _____ Phone #: _____
Informal Support: ☐ Available ☐ Willing to Assist ☐ Unavailable

Referral Source: (Person) _____ (Agency) _____
(Contact Phone #) _____
Hosp ___ MD___ Family___ Community___ SNF___Acute Inpt Rehab___

PLEASE CHECK THE FOLLOWING DOCUMENTS RECEIVED. REQUEST IF NOT PRESENT.

☐ Face Sheet	☐ OR Notes	☐ Discharged Med List
☐ PICC Insertion Notes (if applicable)	☐ Wound Assessment	☐ Discharge Instructions
☐ H&P	☐ Face to Face Encounter document	☐ Recent Labs

REFERRED FOR:	☐ SN (Eval +5)		☐ Telehealth	☐ HHA	☐ Lab Work
	☐ OT (Eval)	☐ PT (Eval)	☐ ST (Eval)	☐ MSW (Eval)	☐ RD (Eval)

Reason for Homecare Referral (Diagnoses & Codes) _____
_____
_____

Surgical DX: _____ Dates: _____

Patient has MOLST ☐ Yes ☐ No	Out of Hospital DNR ☐ Yes ☐ No

B/P: _____ P _____ R _____ T _____ HT _____ WT _____ Last BM _____
Diet/Nutrition: _____ Fluid Restriction: ☐ Yes ☐ No Amount _____
Mental Status: _____

Mobility Assist ☐ Walker ☐ Cane ☐ Crutches ☐ Wheelchair History of Falls ☐ Yes ☐ No

Pressure Ulcer ☐ Yes ☐ No Diabetic Foot Ulcer ☐ Yes ☐ No Stasis Ulcer ☐ Yes ☐ No

Surgical Wound ☐ Yes ☐ No Location _____

Stage of pressure ulcer ☐ I ☐ II ☐ III ☐ IV ☐ Unstageable ☐ Deep Tissue Injury

New 0_2 ☐ New Foley ☐ Size _____ Date last changed: _____

SPECIFIC WOUND CARE:

_____

_____

_____

EQUIPMENT: _____
SUPPLIES: _____
Scripts will be sent for: _____
DME COMPANY: _____ Contact Name: _____ Contact Phone #: _____

Urinary Catheter while Hospitalized? ☐ Yes ☐ No
History of Urinary Tract Infection? ☐ Yes ☐ No

Education Needs: ☐ DM ☐ COPD ☐ CHF ☐ Skin/Pressure Relief Hx of Seizure ☐ Yes ☐ No
Type: _____

Diabetic Testing & Schedule (Be Specific)

_____

Labs needed after D/C with dates:

_____

Scripts for labs will be sent home
Yes ☐ No ☐

CLINICAL FINDINGS:

_____

_____

_____

_____

_____

_____

MEDICATION	DOSE	FREQUENCY	ROUTE	NEW	CHANGE

SOC date of _____ discussed with referral source. Referral source receptive to SOC date and will notify physician and family.

_____ _____ _____
Signature of Person Completing Referral Time Date

_____ _____
Physician's Signature Date