P.O. Box 1050 Scottsboro, Al. 35768
Phone: (256) 259-4840
Fax: (256) 259-4830
(Do not email confidential patient information)

Referral Date: _____/_____/_____ From: ______________________________ Phone: ______-_______-________

Called referral to: Paula Blackwell RN / Lisa Treece RN / Tonya McKee RN / ___________________________________

Pt Name: ____ (may attach demographic sheet)
(FIRST) (MI) (LAST)

Street Address: ____

City: ________________________ **State:** ______ **Zip:** ____________ **Primary Phone:** ______-______-________

Gender: male / female **DOB:** ____/______/_______ **Age:** _____ **Marital Status:** married / single / divorced / widowed

Social Security #: __________-_________-_________

***Medicare #** (*including suffix*) _________________________________

***Medicaid #** __________________________________ (Alabama Medicaid does not cover in-home therapy)

Private Insurance:** __________________________Group#:*** __________ ***Contract #***_______________________________

Referring Physician: _________________________________**Phone:** ________-_______-_________

Will this physician be following this pt post hospital stay? Yes / No

*** IF not who will be the primary care MD?** _________________________ **Phone:** ________-_______-_________

Requested start of care date: _________________________

Referring Diagnosis: 1. ___________ **2.** _____________ **3.** _______________ **4.** ______________ **5.** ________________

Orders for Home Health

___ ***Nursing for : assessment, evaluation, teaching of meds, disease process and self care / wound care / injections /***
Other____

___ ***Home Health Aides for: assistance with personal care*** ***(most private insurances will not pay for this service)***

___ ***Physical therapy:*** ____

___ ***Occupational therapy:*** ____

___ ***Speech therapy:*** ____

****Other orders needs or concerns such as weight bearing precautions, specific wound care orders ETC:***
____

***PLEASE ATTACH A CURRENT MEDICATION LIST AND H&P.**