

Physician/Facility Referral

Patient Name: _____ MD/Facility: _____

Please attach demographics OR complete:

Contact Name: _____

 Address: _____

MD Phone #: _____

MD Fax #: _____

Phone #: _____

Alternate #: _____

 Insurance: Medicare Medi-Cal Other

ID# _____

Patient Emergency #: _____

DOB: _____ SS# _____

Admitting Diagnosis _____

**Telehealth units will be included with diagnosis of: COPD, CHF, DM, Renal Disease,
Pneumonia and Palliative Patients**

<u>Skilled Nursing</u>	<u>Palliative Care</u>	<u>Physical Therapy</u>	<u>Speech Therapy</u>	<u>Occupational Therapy</u>
Assess & Instruct For: <input type="checkbox"/> Medication Mgmt. <input type="checkbox"/> Pain <input type="checkbox"/> Cardiac <input type="checkbox"/> Diabetic Mgmt. <input type="checkbox"/> Respiratory <input type="checkbox"/> Wound <input type="checkbox"/> IV <input type="checkbox"/> Telehealth <input type="checkbox"/> Other	Assess & Instruct For: <input type="checkbox"/> Pain <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Constipation <input type="checkbox"/> Emesis/Nausea <input type="checkbox"/> Psychosocial** <input type="checkbox"/> Music Therapy** <input type="checkbox"/> Chaplain ** <input type="checkbox"/> Dietician** <p style="text-align: center;">**Must accompany skilled nursing**</p>	Evaluate & Treat For: <input type="checkbox"/> Weakness <input type="checkbox"/> Ambulation/Gait Training <input type="checkbox"/> Transfers <input type="checkbox"/> Balance <input type="checkbox"/> Fall Risk/Injury <input type="checkbox"/> Range of Motion <input type="checkbox"/> WBS	Evaluate & Treat For: <input type="checkbox"/> Swallowing <input type="checkbox"/> Impaired Cognition <input type="checkbox"/> Dysphasia <input type="checkbox"/> Dysphagia <input type="checkbox"/> Alternate Communication/Need <input type="checkbox"/> Other	Evaluate & Treat For: <input type="checkbox"/> Safety Training <input type="checkbox"/> Adaptive Equipment <input type="checkbox"/> Cognitive Training <input type="checkbox"/> ADL Retraining <div style="border: 1px solid black; padding: 5px;"> Additional Services Needed: <input type="checkbox"/> MSW <input type="checkbox"/> Home Health Aide <input type="checkbox"/> Telehealth <input type="checkbox"/> Dietician </div>

Wound Orders:

Cleanse With: _____ Apply: _____

Secure: _____ Frequency: _____

Date of Face-to-face encounter: I certify that this patient is under my care and that I, my nurse practitioner or physician's assistant, had a face-to-face encounter on _____.

Please attach and fax these essentials:

Demographics ♦ Insurance Information ♦ History & Physical ♦ last Visit Notes

Physician's Signature: _____ Date: _____

FAX To: (805) 782-8612 ♦ Telephone: (805) 782-8600