



People Home Health Care Services Certified, Inc.
An affiliate of PeopleInc

Submit referral, one of the following ways:

Business Hours 8:30a – 4:00p, Monday – Friday:

- Call Intake Coordinator at (716) 874-5600 | Fax referral form to (716) 566-4988
*** If you do not receive a follow up phone call from us within 1 hour after faxing a referral, please call (716) 874-5600.

Holidays, Weekends and After Hours:

- Call (716) 874-5600 and after hours coordinator will forward your call to On-Call RN

PATIENT DEMOGRAPHIC INFORMATION

Date: Patient's Name: Date of Birth:
Address: Phone Number:
Type of Residence: () Private Home () Group Home () Other:
Primary Insurance: Primary Ins. #: SSN:
Secondary Insurance: Secondary Insurance Number
Primary Caregiver/Next of Kin/POA/Health Care Proxy: Phone Number:
I/DD Diagnosis:
Medical Diagnosis:

PATIENT PHYSICIAN INFORMATION

Name of Referral Source/Title: Phone:
Physician Signing Plan of Care and Orders: Phone:
Physician NPI: Physician Tax ID Number:
Who should be called with questions about referral: Phone:
Requested Start of Care Date:

PATIENT CLINICAL INFORMATION

Is patient currently hospitalized? () yes () no, recent inpatient admission date D/C date:

MENTAL STATUS: (check all that apply)

() Alert () Comatose () Confused () Disorientated () Depressed () Forgetful

FUNCTIONAL LIMITATIONS: (check all that apply)

() Bedfast () Cane () Up as Tolerated () Wheelchair () Walker () Other:

Nursing Services: (Please check all that apply)

Medication Management and Instruction:

() Recent Medication Changes () New Medication () Multiple Medications () Injectable Medications

Disease Management (nursing assessment, education, treatment):

() Hyper/Hypotension () CAD () Heart Failure () COPD () Diabetes

() Other

Wound Care: () Pressure Ulcers () Vascular Ulcers () Post-Surgical Wound () Other

() Current wound care orders:

Rehabilitation and Therapies (PT, OT, Speech):

Indication for Services:

Physical Therapy:

Occupational Therapy:

Speech Therapy:

***Please include demographic form, copies of insurance cards, recent H&P, Medication List, Allergies, Diagnosis list, MOLST/DNR/Health Care Proxy and order for home care services. ***

OFFICE USE ONLY

Approved/Declined by: Date: