VNA of Albany
The Perfect Balance of Healing & Home

REFERRAL FORM - Request for Home Health Services

Name of Practice/Facility______________________________ Type of Facility________________

VNA Phone: (518) 489-2681 *(*Call to confirm receipt of faxed referral)* **Fax: (518) 489-2532**

Facility Admission Date__________ Facility Discharge Date__________ (*Hospitals or Sub-Acute Rehabs Only*)
Patient Name: ____________________________________ D.O.B. ________SEX ____ SSN __________________
Home Address: ____ Phone: _____________________
Caregiver Name____ Phone: _____________________
Name and Address of community MD (*one to sign orders*)
____
____ Phone: _____________________
Principal Diagnosis & date: ____
____
Other Diagnoses & dates: ____
Surgical Procedures & dates: ____
Last Physician Appointment date: __________Was appointment related to reason for home care referral? ☐ Yes ☐ No
Please fax: Discharge Summary from Acute Care Facility, Facility H&P, Discharge Medications/Instructions, Most Current (only) Rehab Notes

Health Insurance Information: Medicare#: ________________________ Medicaid# ________________________
Other Health Insurance: __________________________ Policy# ___________________ Group# ______________
Case Manager: ______________________________Phone #______________Authorization # __________________
Approval given for: ____

Disciplines/Services ordered: Please circle:
RN PT OT ST HHA Social Work WOCN CMHRN CPRN
CDE IV RN Nutrition Pediatrics RN Maternal Child RN PRI

Medications (dose, route and frequency):________________________
____
____

Allergies: _____________________ Diet: ________________________

Weight bearing/activities restrictions: _______________

Functional Limitations: ☐ Amputation ☐ Speech/Hearing ☐ Legally Blind ☐ Limited Manual Dexterity ☐ Cognitive Impairment

Physician's Orders/Treatments/Instructions: ___________________
____
____
____

Referral Source: Person making referral: __________________________
Phone:________________**This referral will be evaluated to determine if patient meets VNA Admission Policy-Intake will contact you with date we may begin service.**

Physician signature/date:

____

* **Referral must be signed by MD** – Center for Medicare and Medicaid does not recognize Nurse Practitioner or Physician Assistant signatures for homecare services.

AVNA parameters	Vital Signs
B/P: 95/50-180/110	
P: 60-100	
Temp: 97-99.5	
Blood Glucose: 70-180	
O2 Sats: > or = to 90%	
Weight gain: notify MD if > 2lbs in 24 hours or 5 lbs in 7 days	
Date service requested to start:	
Patient Essentially Homebound: Yes ☐ No ☐	

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