PREFERRED HOME HEALTH CARE

INDY
Office 317-245-7236
Fax 317-245-7280

Washington
Office 812-254-0063
Fax 812-254-9138

# Intake Form

## Referral Information

Referral Source:______________________ Contact Person: ______________

Telephone #: ____________ Fax #: ______________ Date of Referral: ____________

Anticipated Discharge Date: ______________ Anticipated Start of Care Date:______________

## Patient Information

Patient Name: ______________________ DOB: ________ Phone #: ____________

SS#: ____________ Address: ______________________________________

Emergency Contact Name: __________________ Relationship: _____ Phone#: __________

Emergency Contact Name: __________________ Relationship: _____ Phone#: __________

Primary Physician for Home Care: ______________________ Phone#: ____________

## Payer Source Information

Medicare ID#: ______________________________________________

Medicaid ID#: ______________________________________________

Private Insurance:
Company Name: ______________________________ Phone#: ______________

ID#: __________________________ Group#: ______________________

Private Pay: ________________ Comment: ___________________________

## Projected Needs/Primary Diagnosis

- ☐ Skilled Nursing
- ☐ Physical Therapy
- ☐ Occupational Therapy
- ☐ Speech Therapy
- ☐ Home Health Aide
- ☐ Medical Social Worker

**Medicare ONLY:**
Has patient had a Face To Face visit with the Physician NP, or PA related to the primary reason for home care in the last 90 days?
YES – Get Copy No - Execute
Physician Documentation of Face to Face Encounter form

Primary Diagnosis: ______________________ Secondary Diagnosis: ________________

Physician Signature (if order for referral):______________________ Date:__________