Preferred HOME CARE OF NEW YORK

HOME CARE REFERRAL

Please fax referral to **718.705.6922**
or email to **intake@preferredhcny.com**

CORPORATE HEADQUARTERS
1267 57th Street
Brooklyn, NY 11219
T: 718.841.8000

MANHATTAN OFFICE
1370 Broadway
New York, NY 10018
T: 212.444.9009

☐ General Home Care ☐ Long Term Care ☐ Hospice

Patient Information

Name: Last _____ First _____ MI _____

Address: _____ City: _____ Zip: _____

Social Security: ___-___-_____ Date of Birth: ___/___/_____

Lives Alone: ☐ Yes ☐ No Lives With: ☐ Family ☐ Caregiver ☐ Friend Sex: ☐ Male ☐ Female

Home Phone: (___) ___-_____ Cell: (___) ___-_____ Primary Language: _____

Emergency Contact: _____ Relationship: _____

Home Phone: (___) ___-_____ Cell: (___) ___-_____ Work: (___) ___-_____

Insurance Information

Medicare #: _____ Medicaid #: _____

Commercial Insurance: _____

Policy #: _____ Subscriber: _____ Group #: _____

Physician Signing Home Care Orders

Physician Name: _____ Phone: (___) ___-_____ Fax: (___) ___-_____

Address: _____ NPI #: _____ License: _____

City: _____ State: _____ Zip: _____ Office Contact: _____ Phone: (___) ___-_____

Physician Signature: _____ Date: ___/___/_____

Reason for Home Care/MD Orders

Home Care Diagnosis:

1. .....
2. .....
3. .....

PMH: .....

Allergies: .....

Dietary Restrictions: .....

Is the patient home bound? ☐ Yes ☐ No

Medications / Dose / Frequency / Route: ☐ **Meds list attached**

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Wounds Care Orders: .....

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Supply given: ☐ Yes ☐ No

Prescriptions given: ☐ Yes ☐ No

Medications/Diet Changes: ☐ Teach nutrition

☐ Teach medication and adherence with new/ old regimens

Gait/Ambulatory Status:

☐ Bedbound ☐ Assistive device.....

☐ Evaluate home safety ☐ Assess equipment needs ☐ Unassisted

Did patient have Rehab hospital/Unit admission with in the last 10 days? ☐ Yes ☐ No

Skilled Services:

☐ RN ☐ OT ☐ PT ☐ SLP ☐ SW ☐ HHA

Additional information: .....

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