Please Fax this on: 415-358-9500

# Indira Care Home Health

## PRIVATE DUTY REFERRAL

| Patient Name | | | Date of Birth | Sex: ☐Male ☐Female |
|---|---|---|---|---|
| Patient Address | | | | |
| Patient Phone: | | Alternate Patient Phone: | DPOA/Primary Contact Name: | DPOA/Primary Contact Phone: |
| Height | Weight | Primary Language | Pets ☐Yes ☐ No | Smoker in House? ☐Yes ☐No |
| Allergies | | | Dietary Restrictions | |
| Insurance | | | Social Security Number: | |
| Problem/Diagnosis | | | | |

**Pertinent Information: Check all that apply.**

| | | | |
|---|---|---|---|
| House with ramp | ☐Yes ☐No | Adequate light | ☐Yes ☐No |
| House with grab Bars | ☐Yes ☐No | Adequate water | ☐Yes ☐No |
| House with enough exits | ☐Yes ☐No | Adequate heating | ☐Yes ☐No |
| House with smoke detectors | ☐Yes ☐No | Adequate cooling | ☐Yes ☐No |
| Language barrier | ☐Yes ☐No | Emotional barrier | ☐Yes ☐No |
| Too many pets | ☐Yes ☐No | Cluttered house | ☐Yes ☐No |
| ☐ Lives alone | ☐Lives with other family member | ☐Other:________ ALF ______B&C | |
| ☐ Normal mobility | ☐Uses walker, wheelchair, cane, crutches | | |
| ☐Ambulatory | ☐Bed-bound, wheelchair bound, chair-bound | | |
| ☐Normal mental state | ☐Confused, disoriented, memory loss, dementia, Alzheimer's | | |
| ☐Normal psychosocial | ☐Depressed, apathetic, combative | | |
| ☐Normal vision | ☐Cataract, uses reading glasses, other: | | |
| ☐Normal speech | ☐Expressive/Receptive Aphasia, slurred, non-verbal | | |
| ☐Normal detention | ☐Uses dentures, upper, lower, edentulous | | |
| ☐Normal hearing | ☐Hard of Hearing:______Right, ___Left,_____uses hearing aide | | |
| ☐Normal breathing | ☐Shortness of breath, uses oxygen, uses inhaler, ventilator | | |
| ☐Normal heart | ☐History of hypertension, heart attack, pace maker, other: | | |
| ☐Normal elimination | ☐History of bladder/bowel incontinence, uses diaper x__________/day | | |
| ☐Normal skin | ☐History of skin breaks, wounds, easy bruising, other: | | |
| ☐Normal strength | ☐History of falls, muscle weakness, fractures, tremors, other: | | |

| Medical Equipment: | ☐Hospital bed | ☐Wheelchair | ☐Transfer board |
|---|---|---|---|
| | ☐Hoyer lift | ☐ Front wheel walker | ☐Hand-held shower |
| | ☐Van lift | ☐ Cane | ☐Shower chair |
| | ☐Oxygen | ☐ Crutches | ☐Other: |

Other Comments:

| Referral Source Name | | Date of Referral |
|---|---|---|
| Referral Source Address | Referral Source Phone # | Referral Source Fax # |
| Referral Source Signature | | Date: |