Niche Medical Group

NICHE Home Health Services

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Joint Commission
National Quality Approved

HOME HEALTH REFERRAL / ORDER

PATIENT NAME: ________________________ **MEDICARE #:** ________________

ADDRESS: ________________________ **ZIP CODE**: __________
STREET CITY STATE

DATE OF BIRTH: _____/_____/_______ **AGE:** _____ **SEX:** _____ **TEL. #:** ______________
MM DD YYYY

CONTACT PERSON: ________________ (____________) TEL. #: ______________
RELATIONSHIP

DIAGNOSIS / CONDITION: ________________________________

____

HOSPITAL / NURSING FACILITY: ________________________________

HOSPITAL ADMIT DATE: _____/_____/_______ HOSPITAL D/C DATE: ______________
MM DD YYYY

REFERRAL SOURCE: ________________________________

PHYSICIAN NAME: ________________________ **NPI #:** ______________

TEL. #: ________________________ **FAX #:** ________________________

ORDERS: ***SN TO ASSESS AND EVALUATE FOR HOME HEALTH CARE SERVICES***

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____

MEDICATIONS: ________________________________

ALLERGIES KNOWN: ________________________________

RN SIGNATURE: ________________________ **DATE:** _____/_____/_______
MM DD YYYY

MD SIGNATURE: ________________________ **DATE:** _____/_____/_______
MM DD YYYY

NICHEMED OFFICE USE ONLY

MEDICARE EFFECTIVE DATE A: _____/_____/_______ MEDICARE EFFECTIVE DATE B: _____/_____/_______
MM DD YYYY MM DD YYYY

PATIENT SOCIAL SECURITY #: ______________ MEDICAID #: ______________

SECONDARY INSURANCE: ________________________________

MEDICAL RECORD #: ______________

Patient was ADMITTED to NicheMed for Home Health Services on the following date: _____/_____/_______

Patient was NOT ADMITTED to NicheMed for Home Health Services due to the following: ______________

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