

Referral Source: _____

Phone: _____ Fax: _____

Phone: 937-384-4868

Toll Free: 800-869-5050

Fax: 937-522-7080

FAX REFERRAL FORM

Patient's Name: _____
(first) (middle) (last)

Address: _____

City: _____ State: _____ Zip: _____ County: _____

Phone: _____ DOB: _____ SSN: _____

Diagnosis: _____

Insurance Name: _____ Policy #: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

DNR Comfort Care: Yes No *Medications: Please fax medication sheet and H&P if available _____

Patient must require either SN or PT before other disciplines can be selected.

Please check the following desired disciplines: Skilled Nursing Psych Nursing Physical Therapy Occupational Therapy Speech Therapy
 Home Health Aide Social Worker Dietician/ diet _____

Please circle and/or complete the following as desired: 1. Assess medication compliance
2. Foley Cath: Change pm for leakage, blockage, displacement, routine cath care 3. Diabetes: Instruct and supervisor diabetic regiment
4. Wound/skin care: _____ Dressing: _____
5. Parenteral/Enteral Infusion: Teach / administer, Teach use / care of site: equipment; maintain site _____
6. Administer and teach use of IV medications /equipment/site of IV line Drug, Dose, Frequency, Duration _____

7. Obtain lab work (date): CBC _____ PT/NR _____
 BLC _____ Other _____

Lab Results (physician preference): Phone _____

Pager _____ Fax _____

Line Care:

Type	# Lumens	Groshong	Heparinized
<input type="checkbox"/> CVP	1 2 3	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> PICC	1 2 3	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Port	1 2 3	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Peripheral			

Please indicate if this is the first dose of IV medication: Yes No

Miscellaneous Orders / Comments:

I agree to follow patient for Kettering Network Home Care orders.

Attending Physician Signature: _____ Date: _____

We appreciate the opportunity to serve you and your patients!



**Time to reorder your
Kettering Home Care
fax referral forms!**

Please call: 937-384-4868

or

fax: 937-522-7080

Physician Name/Group: _____

Phone #: _____

Contact Name: _____