General Referral Form

PORTER HILLS
Home Health Care

PATIENT INFORMATION

Patient Name:	DOB:
Date of Surgery: ☐ N/A	Type of Surgery:
Diagnosis/Reason for Referral:	
PCP Name:	PCP Phone Number:
Patient Follow-up Appointment Scheduled For:	

DISCIPLINES

☐ **SKILLED NURSING –** to assess and educate on medication management, disease process, actual/potential complication of disease process, changes in vital signs and/or labs and safety of current living situation.

☐ **OCCUPATIONAL THERAPY –** to evaluate and treat

☐ **PHYSICAL THERAPY -** to evaluate and treat

☐ **SPEECH THERAPY -** to evaluate and treat

☐ **MSW –** to evaluate and treat any psychosocial concerns.

ADDITIONAL INFORMATION

IN ADDITION TO THIS REFERRAL FORM, PLEASE FAX PORTER HILLS HOME HEALTH CARE THE FOLLOWING AT 616.575.5123 OR EMAIL PHHCReferrals@MyBrio.org:

☐ Face Sheet; including demographics and insurance

☐ Most recent visit note

☐ Reason for home care referral