HCR Home Care

Home Care Referral

Available to see patients 7 days a week—including Saturday and Sunday!

FAX COMPLETED FORM TO 888-705-4843/CALL US AT 800-270-4904

Patient Information: *(you may attach a demographic/face sheet in lieu of patient information)* **Date Form Completed:** _____

Name: _____ Nickname/Preferred Name: _____

Gender: ☐ Male ☐ Female ☐ Transgender Male ☐ Transgender Female ☐ Other: _____

☐ LGBTQ+ Care Program Pronouns: _____

Primary Support: ☐ Significant Other ☐ Partner _____ Phone: _____

Social Security #: _____ Date of Birth: _____

Primary Language: ☐ English ☐ Spanish ☐ Russian ☐ Ukrainian ☐ Other: _____

Address: _____ Apartment #: _____

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

☐ Independent Living Community (ILF) ☐ Assisted Living Program (ALP) ☐ Assisted Living Residence (ALR) ☐ Enriched Housing Program (EHP)

Phone: ( ) _____ **Insurance & Policy #:** _____

Referral Source/Sender Contact: _____ Referring Source Phone: ( ) _____

Physician: _____ Physician Phone: ( ) _____

Date of last MD visit: _____ ***Please attach last visit note****

Date of start of services, if applicable: _____

☐ If no date specified, start of services to be scheduled within 48 hours of receipt of complete referral, unless otherwise notified

***Last video or in-office visit note is necessary to start services**

Reason for Referral: _____

_____

Primary Medical Diagnosis Home Care Will Be Treating: _____

Please check all the services you are requesting for your patient:

☐ **Skilled Nursing:** ☐ Disease Management/Teaching ☐ Medication Management ☐ Cardiopulmonary Status ☐ Wound Care
☐ PRI Screen ☐ Telehealth Monitoring ☐ Observation/Assessment ☐ IV Therapy ☐ Transcultural Care ☐ UAS
☐ Evaluation for HHA (requires other skilled need) ☐ Other: _____

☐ **Physical Therapy:** ☐ Joint Replacement ☐ Fall Risk Assessment ☐ Assistive Device Teaching ☐ Strength/Endurance Training
☐ Gait Training ☐ Balance Training ☐ Home Safety Evaluation ☐ Energy Conservation
☐ Orthopedic Prescreen (Home visit prior to surgery—Check for availability in your area)

☐ **Occupational Therapy**: ☐ ADL Function/Training ☐ Cognitive Function ☐ Neuromuscular Retraining
☐ Toileting ☐ Bathing ☐ Dressing/Grooming ☐ Meal Preparation ☐ Self Administration of Medication

☐ **Speech Therapy:** ☐ Cognition ☐ Swallow Evaluation ☐ Texture Modification

☐ **Social Worker:** ☐ Assess needs for community resources ☐ LTC Placement/Planning ☐ Financial Planning ☐ Caregiver Support

Information Attached: ☐ Medication List ☐ Last Visit Note ☐ Problems List ☐ Demographic Sheet
☐ If in a ILF, ALP, ALR, or EHP: Individualized Service Plan (ISP) ☐ Other: _____

Finger Lakes/WNY Region: Genesee/Orleans | Livingston | Monroe | Ontario | Wayne | Wyoming
Central NY Region: Cayuga | Chenango | Cortland | Jefferson | Madison | Oneida | Onondaga | Oswego
Catskill Region: Delaware | Otsego | Schoharie
North Country Region: Clinton | Essex | Franklin | Hamilton | St. Lawrence | Warren | Washington

Are Costs Covered by Insurance?
Coverage is based on each individual case. Medicare, Medicaid, and most insurance plans are accepted. A nursing assessment can determine coverage —refer your patient for an assessment today!