HOME CARE REFERRAL FORM

Fax Number: 855.536.4893
Intake Phone: 559.742.8005
www.lenity3.com
Available every day of the year 24/7

LENITY HOME CARE
KINDNESS • GENTLENESS • HUMANITY

Start of Care Date (if requested): ________/________/________

Patient Information

□ See Attached Demographic Sheet

Patient Name: ______________________________ Patient Date of Birth ____/____/_____

Patient Address: Street: ____

City: ____________________ State: ______ Zip: __________ County: ________________

Patient Phone(s): ____

Patient Insurance Policies & Numbers: ______________________________

Emergency Contact Name: ________________________ Relationship: ______________

Phone: ________________________ Contact Email: __________________________

Physician Ordering Home Health: ______________________________________

Physician Phone Number: ____

Date of Last Doctor's Appt.: ________/________/________

Primary Diagnosis: ____
____

Lenity Home Care is to provide the following medically necessary services:
(reason must be filled out for face-to-face):

□ RN: ______________________________ □ ST: ______________________________

□ PT: ______________________________ □ HHA: ______________________________

□ OT: ______________________________ □ MSW: ______________________________

(OT, MSW or HHA cannot be ordered without PT or RN)

Other services needed:

□ Home Safety Eval (SN)
□ Medication Compliance (SN)
□ Diabetic Teaching (SN)
□ Wound Care (SN)
□ Foley/Ostomy (SN)
□ IV Therapy (SN)

□ Strength/ROM Training (PT, OT)
□ Transfer Training (PT, OT)
□ ADL Training (PT)
□ DME Training (PT, OT)
□ Other(s):
□ Nurse Alert

□ Other Services (not specified):
____
____
____
____
____

Physician Signature: ______________________________________ Date: ____/____/_____