REFERAL FORM

Doctor1@nextgenms.us	MD ID: Comes here...

Name of Agency : NIRVANA HH

Home Health Service

- [x] ForSkillNursingServices
- [ ] ForPhysicalTherapyTreatment
- [ ] ForOccupationalTherapy

Treatment

- [ ] PainManagement
- [x] Psychiatry
- [ ] Neurology
- [ ] WoundCareSpecialist

Lab(s) _____

- [x] Lipid Panel
- [ ] Renal Profile
- [ ] Urine Culture And Sensitivity
- [ ] ANS/ QSART Test (Evaluation For Autonomic Nervous System)
- [ ] EKG
- [ ] TSH, T3, T4
- [ ] CBC
- [ ] BMP
- [ ] Cardiac Enzymes
- [ ] CT
- [ ] Liver Profile
- [ ] Echocardiogram
- [ ] CMP
- [ ] Respiratory Swab
- [ ] A1C
- [ ] B 12
- [ ] Ultrasound Bilateral Lower Extremities For DVT
- [ ] Urinalysis With PCR If (+)
- [x] PSA
- [ ] Vitamin D
- [ ] Chest X-Ray
- [x] Pneumonia Sputum

Provider Name: Name Signature: _____
Date: Date here

Medical Provider Name: Name Signature: _____
Date: Date here

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ADMISSION ORDERS

NEW MEDICATIONS ☐ Spanish Translation

#	Date	Medication Name	Dose	Route	Frequency	Purpose
1	2024-06-26	panadol	2 daily	Po	Topical	QD

Treatment Orders

☐ Discontinue

☑ Refill Medications

DIET	☑ Dash ☑ Renal ☑ Diabetic ☐ Mechanical Soft ☐ Pureed ☐ Thickened Liquid
DME	☑ Cane ☑ WheelChair ☐ Ankle Support ☐ ShowerChair ☐ Walker ☐ Compression Stockings ☐ BP Machine ☐ Commode ☐ Back Support ☑ Knee Support
SUPPLIES	☑ Pull Ups Small ☐ Under Pads ☐ Bed Pan ☐ Pull Ups Medium ☐ Pull Ups Large ☑ Glucose Test Strips

Refer To:

☑ Home Health Due To	Name of Health Agency: NIRVANA HH Name of Hospice Agency: Name of hospice		
☑ Cardiology	Name cardio name	Tel: 123456789	Location: location
☑ WoundCare	Name name	Tel: 123456	Location: location
☑ Surgery Procedure: procedure	Name name	Tel: 123456	Location: location
☑ Pain Specialist	Name name	Tel: 12346	Location: location
☑ Orthopaedic	Name name	Tel: 123456	Location: location

Laboratory and Diagnostics

☑ Ans/QSART Test Evalution For Automatic Nervous System	☐ Ultrasound Bilateral Lower Extremities Arteries And Veins	☐ Echocardiogram
☐ AIC	☑ Pneumonia Sputum	☐ B12
☐ Chest X-Ray, VI	☐ Lithium Level	☐ Renal Profile
☐ VitaminD	☐ EKG	☐ BMP
☐ Liver Profile	☐ CBC	☐ CT
☐ Urine Culture & Sensitivity	☐ TSH, T3, T4	☐ CMP
☐ PSA	☐ Cardiac Enzymes	☑ LIPID Panel

Provider Name: Name Signature: _____
Date: Date here

Physician Name: Name Signature: _____
Date: Date here

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IMPRESSION / PLAN DX

☐ Transitional Care

Stroke	Patient may have the formation of an area of necrosis in the cerebrum caused by an insufficiency of arterial or venous blood flow. Infarcts of the cerebrum are generally classified by hemisphere (i.e., left vs. Right), lobe (e.g., frontal lobe infarction), arterial distribution (e.g., infarction, anterior cerebral artery), and etiology (e.g., embolic infarction).
Mucosa: Dry	Patient may have dry mouth, a symptom that leads to a lack of saliva. Individuals with dry mouth do not have enough saliva to keep the mouth wet.

Advanced Care Planning: Advanced care planning with patient, time spent **15** minutes. Reviewed care plan options such as code status, intubation and hospitalization. Reviewed risks of cardiac resuscitation including rib fracture. Reviewed prolong life expectancy and benefit to aggressive care and treatment.

Orders: AS ATTACHED

Discussion Notes:

Lorem ipsum dolor sit amet consectetur adipisicing elit. Accusamus fugiat dolores numquam possimus quod corrupti omnis laborum ab dolorem! Velit possimus, atque amet quaerat soluta dignissimos earum similique voluptatem a.

INITIAL ASSESSMENT FORM

☐ Initial Visit	☐ Name / ☐ Name	☐ Name	Dos
Chief Complaint			

ALLERGIES

Drug / Food	**Reaction**	
Name of the drug	Reaction Description	
☐ Penicillin	☐ Sulfa	☐ No Known Allergies

Functional Limitations		**Activities Permited**
☐ Amputation ☐ Legally Blind ☐ Weakness ☐ Contracture ☐ Confused ☐ Speech	☐ Paralysis ☐ Bowel/Bladder ☐ SOB Minimum Exertion ☐ Ambulation ☐ Hearing ☐ Vision Deficit	☐ Complete Bedrest

PAST SURGICAL HISTORY

☐ Name

PAST SURGICAL HISTORY

☐ Name	☐ Name	☐ Name	☐ Name

Social History

Tobacco / THC	☐ Yes	☐ No	☐ Daily	☐ Socially	☐ Occasionally
ETOH/Alcohol	☐ Yes	☐ No	☐ Daily	☐ Socially	☐ Occasionally
Drugs	☐ Methamphetamines	☐ Cocaine	☐ Heroin	☐ Ecstasy	

REVIEW OF SYSTEM / PHYSICAL EXAMINATION

VITALS

HT	**WT**	**TEMP**	**BP**	**HR**	**RR**	**02 SAT**
Date	Meds	Dos	Rout	Freq	Purpose	Purpose

System	**WNL**	**FINDINGS**
General	WNL...	☐ Name ☐ Name ☐ Name ☐ Name
Head	WNL...	☐ Name ☐ Name ☐ Name ☐ Name
Neck, Axilla, Breasts	WNL...	☐ Name ☐ Name ☐ Name ☐ Name
Eyes	WNL...	☐ Name ☐ Name ☐ Name ☐ Name
Ears	WNL...	☐ Name ☐ Name ☐ Name ☐ Name
Nose	WNL...	☐ Name ☐ Name ☐ Name ☐ Name
Mouth	WNL...	☐ Name ☐ Name ☐ Name ☐ Name
Cardiovascular	WNL...	☐ Name ☐ Name ☐ Name ☐ Name
Pulmonary	WNL...	☐ Name ☐ Name ☐ Name ☐ Name
Abdomen	WNL...	☐ Name ☐ Name ☐ Name ☐ Name
Genitourinary	WNL...	☐ Name ☐ Name ☐ Name ☐ Name
Rectal	WNL...	☐ Name ☐ Name ☐ Name ☐ Name
Upper extremities	WNL...	☐ Name ☐ Name ☐ Name ☐ Name
Lower extremities	WNL...	☐ Name ☐ Name ☐ Name ☐ Name

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System	WNL	FINDINGS
Skin	WNL...	☐ Name ☐ Name ☐ Name ☐ Name
Nutrition	WNL...	☐ Name ☐ Name ☐ Name ☐ Name
MUSCLE SKELETAL	WNL...	☐ Name ☐ Name ☐ Name ☐ Name
Endocrine	WNL...	☐ Name ☐ Name ☐ Name ☐ Name
Pelvic	WNL...	☐ Name ☐ Name ☐ Name ☐ Name
Neurological	WNL...	☐ Name ☐ Name ☐ Name ☐ Name
Mental	WNL...	☐ Name ☐ Name ☐ Name ☐ Name

ASSESSMENT/DIAGNOSIS
Diagnosis comes here...

PLAN		
☐ Send To ED Now	☐ Follow Up In 1 Week With ECP	☐ Continue Current Medications/ Treatment
☐ New Med/Tx/Sup/DME: See Orders	☐ Labs/Diagnostics: See AdmissionOrders	☐ Referrals: See Admission Orders
☐ Wellness/Preventive Intervention	☐ PT/OT/HH For Disease Or Pain Management	☐ Refill Medications

Provider Name: Name
Date: Date here
Signature: _____

Physician Name: Name
Date: Date here
Signature: _____

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Pega Report Demo

FACE TO FACE ENCOUNTER

Home Health: Home health name... **Date of Service** Date here...

I certify that this patient is under my care and that I, or an allowed Nurse practitioner or Physician's assistant working in collaboration with me, had a face-to-face encounter that meets physician face-to-face-encounter requirements with this patient on:

Month Month here... **Day** Day here... **Year** Year here...

Clinical Summary of Findings from Face-to-Face Encounter in Support of Home Health Need:
(Require up to 90 days prior to initial SOC, is relevant to the reason for the patient's need for home health services, or within 30 days after the start of care if the 90-day prior encounterdid not take place.)

Medical Condition Related to Home Health Services:
The encounter with the patient was in whole, or in part, for the following medical condition, which is the primary reason for home health care because

☐ HTN	☐ HLD	☑ DIABETES Type 1 2	☐ GERD / Gout
☐ COPD / Asthma / Dyspnea	☐ Limited Ambulation	☐ OA	☐ Depression
☐ Anxiety	☐ Insomnia	☑ Constipation	☐ Hyperthyroidism
☐ BPH/ Overactive Bladder	☐ Memory Loss	☐ Dizziness	☐ Tobacco Use
☐ Vitamin D Deficiency	☑ Neuropathy / Sciatica	☐ Muscle Cramp	☐ Ble Weakness/Ble Edema
☐ PVD / DVT / CAD	☐ Schizophrenia	☐ Arthritis / Osteoarthritis	☐ Iron Deficiency Anemia
☐ Stroke	☐ Mild Mental Retardation	☐ Herniated Disc	☐ Angina Pectoris
☐ Venous Insufficiency	☑ Hypertensive Heart Disease Without Heart Failure	☐ LBP, Knee / Shoulder Pain	☐ Hypothyroidism
☐ Myocardial Infarction	☐ ATRIAL Fibrillation	☐ Dementia / Alzheimer's	☐ Cancer
☐ Seizure	☐ Hypertensive Heart Disease With Heart Failure	☐ Nausea/Vomit/Diarrhea	☐ Congestive Heart Failure
☐ Hyperlipidemia	☐ Chronic Migraines	☐ Parkinson's	☐ History Of Falls
☐ Chronic Kidney Stage 1 / 2 / 3	☐ SOB With Exertion	☐ Bipolar / Psychosis	☐ Arrhythmia
☐ Asthenia / Unsteady Gait			

I further certify that, based on my findings, this patient is homebound (i.e. absences from home require considerable and taxing effort, and for medical reasons or religious services, or infrequently, or of short duration when for other reasons) due to the following services that are medical necessary from home health (Check allthat apply):

☐ Skilled Nursing	☐ Ostomy Care	☐ Speech Pathology	☐ Cardiac/CHF Care
☐ Home Health Aide	☐ Occupational Therapy	☐ Physical Therapy	☑ Medical Management
☑ Diabetic Care	☐ Neurological Care	☐ Foley Catheter Care	☐ Stroke Care
☐ G.T. Care	☐ Wound Care	☐ Strengthening/Balance	☐ Social Worker
☐ Dialysis Care / AV Fistula	☐ Psychiatry	☐ Orthopedic Care	☐ COPD Care

Certificate of Homebound Status:
My clinical findings from this encounter support the patient is homebound due to:

☐ Requires The Assistance Of 1-2 People To Ambulate	☐ Poor Ambulation – Prone To Falls	☑ Medical Restrictions: Open Draining Wound, Legs Elevated All Times	☑ Impaired Ability To Unsafe To Drive
☐ Confusion/Disorientation	☑ Unable To Leave Home Without Maximum Assistance And/Or Effort	☐ Debilitating Dizziness	☐ Compromised Mental Status
☐ Difficult And Taxing Effort To Leave Home	☐ Unable To Ambulate	☐ Requires An Assistive Device To Ambulate	☐ Post-Op Weakness
☐ Unsteady Gait With Assistive Device	☐ Debilitating Dyspnea On Exertion	☐ Unable To Negotiate Stairs	

Provider Name: Name Signature: _____
Date: Date here

Physician Name: Name Signature: _____
Date: Date here

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Pega Report Demo

TELE MEDICINES

Home Health: Home health name... **Date of Service** Date here...

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☐ COPD / Asthma / Dyspnea	☐ Limited Ambulation	☐ OA	☐ Depression
☐ Anxiety	☐ Insomnia	☐ Constipation	☐ Hyperthyroidism
☐ BPH/ Overactive Bladder	☑ Memory Loss	☐ Dizziness	☐ Tobacco Use
☐ Vitamin D Deficiency	☐ Neuropathy / Sciatica	☐ Muscle Cramp	☐ Ble Weakness/Ble Edema
☐ PVD / DVT / CAD	☐ Schizophrenia	☐ Arthritis / Osteoarthritis	☐ Iron Deficiency Anemia
☐ Stroke	☐ Mild Mental Retardation	☑ Herniated Disc	☐ Angina Pectoris
☐ Venous Insufficiency	☐ Hypertensive Heart Disease Without Heart Failure	☐ LBP, Knee / Shoulder Pain	☐ Hypothyroidism
☐ Myocardial Infarction	☐ ATRIAL Fibrillation	☐ Dementia / Alzheimer's	☐ Cancer
☐ Seizure	☐ Hypertensive Heart Disease With Heart Failure	☐ Nausea/Vomit/Diarrhea	☐ Congestive Heart Failure
☐ Hyperlipidemia	☐ Chronic Migraines	☐ Parkinson's	☐ History Of Falls
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☐ Asthenia / Unsteady Gait			

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☐ Unsteady Gait With Assistive Device	☐ Debilitating Dyspnea On Exertion	☐ Unable To Negotiate Stairs	

Provider Name: Name Signature: _____
Date: Date here

Physician Name: Name Signature: _____
Date: Date here

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HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTHCARE PROVIDERS AS NECESSARY

EMSA #111B
(Effective 10/1/2014)

Physician Orders for Life-Sustaining Treatment (POLST)

First follow these orders, then contact physician. A copy of the signed POLST form is a legally valid physician order. Any section not completed implies full treatment for that section. POLST complements an Advance Directive and is not intended to replace that document.

Patient Last Name:	Date Form Prepared:
Patient First Name:	Patient Date of Birth:
Patient Middle Name:	Medical Record#

A
Check One

CARDIOPULMONARY RESUSCITATION (CPR): If patient has no pulse and is not breathing. If patient is NOT in cardiopulmonary arrest, follow orders in Sections B and C.

- ☐ Attempt CPR
- ☐ Do Not Attempt CPR

B
Check One

MEDICAL INTERVENTIONS: If patient is found with a pulse and/or is breathing.

- ☐ Attempt CPR
- ☐ Do Not Attempt CPR

C
Check One

ARTIFICIALLY ADMINISTERED NUTRITION: Offer food by mouth if feasible and desired.

- ☐ Attempt CPR
- ☐ Do Not Attempt CPR

D
Check One

INFORMATION AND SIGNATURES:

Discussed with:	☐ Patient (Patient Has Capacity)	☐ Legally Recognized Decisionmaker
☐ Advanced Directive Dated Date comes here ,available and reviewed -> ☐ Advance Directive Not Available ☐ No Advance Directive	**Healthcare Agent if named in Advance Directive:** Name: Name Phone: Phone	
Signature Physician: My signature below indicates to the best of my knowledge that these orders are consistent with the patient's medical condition and preferences.		
Print Physician Name: Name here...	Phone: Phone	License #: License#
Physician Signature: Signature...		Date: Date
Signature of Patient or Legally Recognized Decisionmaker: I am aware that this form is voluntary. By signing this form, the legally recognized decisionmaker acknowledges that this request regarding resuscitative measures is consistent with the known desires of, and with the best interest of, the patient who is the subject of the form.		
Print Name: Name		Relationship (write self if patient): Relationship
Signature: Signature		Date: Date
Mailing Address (street/city/state/zip): Address	Phone: Phone	Office Use Only: Office Use Only

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MEDICATION RECONCILIATION

Phone: Number
HICN: HICN#
DIAGNOSIS: DIAGNOSIS ALLERGIES: ALLERGIES
HEIGHT: HEIGHT WEIGHT: WEIGHT
REVIEWED FOR CONTRAINDICATIONS: YES NO
REVIEWED FOR INTERACTIONS: YES NO
PHARMACY NAME: PHARMACY NAME
ADDRESS: address
PHONE: phone

Prescribed Medications	DOSE	ROUTE	FREQUENCY	PURPOSE	REFILLS
a	1	Po	Topical	BID	1
b	2	Po	Topical	BID	2

See Attachment

ASSIGNMENT OF INSURANCE BENEFITS

Medicare Certification: I certify that the information provided by me in applying for payment under TITLE XVII of the Social Security Act is correct and request on my behalf all authorized benefits. I hereby authorize and instruct my insurance carrier to make payment directly to Remedial Patients Care, Inc. for benefits (payments) otherwise payable to me. I agree to personally pay for any charge that are not covered by or collected from any insurance program including any deductibles and coinsurance amounts.

I certify that all information given are correct and consent to the release of all records for payment of authorized benefits from Medical, Medicaid, or any other responsible payer be made in my behalf to Remedial Patients Care, Inc.

I understand that the Federal Patient Self -Determination Act of 1990 requires that I be made aware of my right to make healthcare decision for myself. I understand that I may guess express my wishes in a document called an Advance Directives so that my wishes may be known when I am unable to speak for myself.

1. I have a Living Will declarations ☐ Yes ☐ No
   (If yes, please provide a copy of your will.)
2. I have a Durable Power of Attorney for Health Care ☐ Yes ☐ No

Name of Patient	
Name of Patient	Date of Birth
Address	
Signature of Patient:	Date:

LEGAL REPRESENTATIVE (IF PATIENT IS UNABLE TO SIGN)

Consent of Legal Guardian, Patient Advocate or Nearest Relative if patient is unable to sign
Consent of Caregiver if patient is unable to sign (Must have Power of Attorney)

Name of Legal Representative:				
Relationship:		Telephone:		
Address:				
Unit:	Street:	City:	State:	Zip:
Signature of Legal Rep:		Date:		
Name of Witness:		Sitnature:		Date:
Reason patient is unable to sign:				

ANNUAL WELLNESS FORM

Current list of patient's providers and suppliers	Name	Speciality	Reason	
	sample name	sample Speciality	sample reason	
Special Diet YES NO	Description:	Diabetic	Dash	
Cognitive Impairment	None	Dementia	Mild Memory Loss	
List of medication, supplement and vitamins	Please see attach			
Depression screening	Felt depressed/hopeless over the last 2 weeks	YES NO	Evaluation/Referrals: Schedule Appointments:	Notes:
	Little or no pleasure in doing thing over the last 2 weeks	YES NO	Evaluation/Referrals: Schedule Appointments:	Notes:
Hearing loss screening	Trouble hearing television or radio when others do not	YES NO	Evaluation/Referrals: Schedule Appointments:	Notes:
	Strain or struggle to hear/understand conversations	YES NO	Evaluation/Referrals: Schedule Appointments:	Notes:
Home safety screening	Throw rugs, poor lighting or slippery bathtub/shower at home	YES NO	Evaluation/Referrals: Schedule Appointments:	Notes:
	Lack of grab bars, bathrooms, handrails on stairs and steps at home	YES NO	Evaluation/Referrals: Schedule Appointments:	Notes:
Fall risk screening	Unsteady or take longer han 30 seconds to get up and go	YES NO	Evaluation/Referrals: Schedule Appointments:	Notes:
Advance care planning	Patient consent: I consent to discuss end-of- life issues with my healthcare provider	PATIENT SIGNATURE		DATE
	Patient has already executed an advance directive	YES NO		
	If no, patient was given an opportunity to execute an Advance Directive	YES NO		
	Physician statement: “Patient has the ability to prepare an Advance Directive.”	YES NO		
	Physician has completed a Order of Life-Sustaining Treatment, or similardocument of another name, reflecting the patient’s wishes	YES NO		
	Physician SIGNATURE			DATE

Preventive screening (frequency) Screened Schedule (5-10 Years)	Coverage		Previously Screening If YES (When)	
Bone mass measurements (every 24 months)	Medicare patients at risk for developing osteoporosis			NEEDS
Cardiovascular screening blood tests (every 5 years) <Lipid panels> <Cholesterol> <Lipoprotein> <Triglycerides>	All asymptomatic Medicare patients (12-hour fast is required)			NEEDS
Colorectal cancer screening, flexible sigmoidoscopy (4 years, or once every 10	Medicare patients age 50 and up; for screening colonoscopy, those at high risk, no			NEEDS

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years after screening colonoscopy) **Screening Colonoscopy** (every 24 months at high risk; every 10 years not at high risk) **Fecal occult blood test** (annually) **Barium enema** (every 24 months at high risk, every 4 years not at high risk)	minimum age; no minimum age for having a barium enema as an alternative to a high risk screening colonoscopy if the patient is at high risk			
Diabetes screening tests (2 screening tests per year for patient diagnosed with pre-diabetes; 1 screening per year if previously tested, but not diagnosed with pre-diabetes or if never tested)	Medicare patients with certain risk factors for diabetes or those diagnosed with pre-diabetes (patients previously diagnosed with diabetes aren't eligible)			NEEDS
Diabetes Self-Management Training (DSMT) and Medical Nutrition Therapy (Up to 10 hours of initial training within a continuous12-month period; subsequent years up to 2 hours of follow-up training each year after initial year)	Medicare patients at risk for complications from diabetes, recently diagnosed with diabetes or previously diagnosed with diabetes (must certify DSMT need)			NEEDS
Glaucoma screening (annually for patient in one or more high risk groups)	Patients with diabetes mellitus, family historyor glaucoma, African-Americans age 50 andup, or Hispanic-Americans age 65 and up			NEEDS
Prostate cancer screening (annually) Digital rectal exam Prostate-specific antigen test	Male Medicare patients 50 and up			NEEDS
Screening PAP tests and pelvic examination (Annually if high-risk, or child bearing age with abnormal PAP test within past 3 years; every 24 months for all other women)	Female Medicare patients			NEEDS
Screening mammography (annually)	All female patients 40 or older			NEEDS
Vaccines <Pneumococcal> (Once in a lifetime) <Seasonal influenza> (once per flu season in the fall or winter) <Hepatitis B> (scheduled dosages required)	All Medicare patients; may provide additional pneumococcal vaccinations based on risk and if at least 5 years have passed since previous dose; for hepatitis B, if patient is medium/high risk			NEEDS