Skilled Nursing Facility to Home Health Referral Form

Accessible Home Care LLC

Please complete all fields and attach all required documents to ensure timely and safe admission.

PATIENT INFO & PHYSICIAN

First Name: _____ **Last:** _____ **Certifying Physician:** _____

DOB: ____/____/____ Phone: _____ Fax: _____

County: _____ **City:** _____ **Zip :** _____ ICD-10: _____ Dx: _____

Home Address: _____ F2F Date: __/__/__ **(ATTACH F2F)** ☐ F2F is Attached

Referring SNF: _____ **Homebound Status:** _____

SOC Date: ____/____/____ Code: ☐Full ☐DNR ☐DNH ☐Comfort

Emergency Contact: _____ Relationship: _____ Phone: _____

PLAN OF CARE

Discipline	Request	Notes / Specific Orders and Recommendations
Skilled Nursing (SN)	☐Y ☐N	
Physical Therapy (PT)	☐Y ☐N	
Occupational Therapy (OT)	☐Y ☐N	
Speech Therapy (ST)	☐Y ☐N	
Home Health Aide (HHA)	☐Y ☐N	

Additional Orders:

☐ Dietary ☐ Activity Restrictions ☐ Wound Care ☐ IV/Infusion

☐ Oxygen (Attach medication list & specific orders): _____

LOGISTICAL & HIGH-RISK DETAILS

Medications	**Med List**	**MUST ATTACH - Home meds only (exclude facility PRNs)**
	Allergies	☐ None ☐ Yes: _____
IV/Infusion	**IV Company**	_____
	Next Dose Due	Date: __/__/__ Time: _____ ☐AM ☐PM
	IV Line Type	☐ PICC ☐ Central ☐ Peripheral ☐ Other: _____ Inserted: __/__/__
Oxygen	**Ordered?**	☐ Yes ☐ No Flow: ____ L/min ☐ NC ☐ Mask
	Delivery Status	Date/Time O2 delivered to home: _____
Devices	**Present**	☐ Foley ☐ Feeding Tube (Type:_____)
	Infection Control	MDRO precautions? ☐ Yes (Specify: _____) ☐ No
Follow-Up	**Pending Tests/Appts**	_____

Notes: _____

REQUIRED ATTACHMENTS

☐ Face-to-Face (F2F) Documentation

☐ Physician Orders (as applicable)

☐ Complete Medication List (Home Meds Only)

☐ DNR/Advance Directive (if applicable)

Referring RN/Case Manager: _____ **Facility Name:** _____

Date: _____ **Contact Phone:** _____ **Fax:** _____

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100 N 7th St, Ste 206, Salina, KS
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