Sutter Health
Sutter Care at Home

HOME HEALTH REFERRAL

Thank you for your referral! Please fax this referral sheet with the following:
1) H&P / Discharge Summary, 2) Current Medication List, 3) *Medicare patients only*: completed Medicare Certification ("Face to Face")

	Phone	Fax		Phone	Fax
Sacramento (& Yolo County)	916-388-6260	916-381-1769	**Concord** (Solano, Contra Costa Counties)	925-677-4258	925-687-9182
Roseville (Placer, Eldorado Counties)	916-797-7988	916-797-7980	**San Leandro** (Alameda County)	510-618-5240	510-347-6874
Yuba City (Sutter County)	530-749-3510	530-749-3413	**San Francisco**	415-749-4230	888-740-1372
Central Valley	209-342-4091	209-521-4302	**San Mateo** (& Santa Clara County)	650-685-2828	650-685-2820
Lakeport	707-263-7400	707-263-1964	**Santa Cruz**	831-477-2633	855-729-1212
Santa Rosa	707-535-5656	855-604-3218	**Salinas** (Monterey County)	831-240-4389	831-455-2044
Marin	415-209-7760	888-521-4799			

Patient Demographics

First Name		Last Name		M.I.	
Date of Birth		Sex ☐ M ☐ F	Home Phone		Mobile Phone
Home Address	Street		City		Zip
Service Location (if not home address)	Street		City		Zip
Caregiver / Emergency Contact			Phone		
Insurance	☐ Medicare ☐ Medi-Cal ☐ Commercial Insurance:			ID #	
Diagnosis(es)					

Home Health Orders

Please Check All Home Health Services Ordered:

☐ **Skilled Nursing, Evaluate & Instruct:**
- ☐ Cardiac ☐ Diabetes
- ☐ Home Health Aide ☐ Medication
- ☐ Pain ☐ Respiratory
- ☐ Advanced Illness Management (AIM) / Palliative Care
- ☐ Wound Care:
  - Type: ______________________
  - Location(s): ______________________
  - ______________________
  - Stage: ______________________

☐ **Physical Therapy, Evaluate & Instruct:**
- ☐ Ambulation / Gait ☐ Balance
- ☐ Bed Mobility ☐ Range of Motion
- ☐ Safety / Falls ☐ Transfers
- ☐ Weakness / Strengthening
- ☐ Wheelchair Mobility
- ☐ Other: ______________________

☐ **Speech Therapy, Evaluate & Instruct:**
- ☐ Cognition ☐ Hearing
- ☐ Language Processing
- ☐ Swallowing
- ☐ Voice Intelligibility
- ☐ Other: ______________________

☐ **Home Infusion** (please attach orders separately)

☐ **Sutter Comprehensive Joint Replacement (CJR) Pre-Op Coordination Visit**
Note: available for contracted Sutter hospitals only
Scheduled Surgery Date: ______________
☐ TKR ☐ THR ☐ Posterior ☐ Anterior

☐ **Medical Social Work, Evaluate & Instruct:**
Note: to order MSW, either Skilled Nursing, Physical Therapy, or Speech Therapy must also be ordered.
- ☐ Family Support System
- ☐ Alternate Living ☐ Counseling Referral
- ☐ Stress/Coping/Grief ☐ In-Home Assistance
- ☐ Unsafe Environment
- ☐ Other: ______________________

☐ **Occupational Therapy, Evaluate & Instruct:**
- ☐ ADLs ☐ Energy Conservation
- ☐ Sensory Dysfunction ☐ Orthotics
- ☐ Equipment & Adaptive Devices
- ☐ Other: ______________________

Comments:

Physician Information

Referring Physician (please print)		Phone Fax
Following Physician (please print, if different)	☐ same as referring physician above	Phone Fax
Physician Signature	*By signing, I am confirming referral orders and diagnosis listed:*	Date