CLEAR

IN GOOD FAITH HOME CARE REFERRAL FORM

(800) 689-7005
www.ingoodfaithhomecare.com
6920 S. East Street, Ste. B
Indianapolis, IN 46227

Please fax or email all referral requests to:

(800) 789-6482
support@ingoodfaithhomecare.com

Referral Date: _____ Proposed Service Start Date: _____

1. CLIENT DEMOGRAPHIC INFORMATION

First Name: _____ Middle Initial: _____ Last Name: _____

Suffix: _____ Date of Birth: _____ Gender: Male: ☐ Female: ☐ Other: ☐

Pronoun: _____ Social Security Number: _____ Primary Language: _____

Service Address: _____

_____

Home Phone Number: _____ Cellular Phone Number: _____ Email Address: _____

2. EMERGENCY CONTACT/REPRESENTATIVE INFORMATION

Emergency Contact Name: _____ Emergency Contact Phone Number: _____

Does the client have a guardian, attorney-In-fact, health care representative, or other legal representative?

Yes ☐ No ☐ *If yes, please complete the following:*

Representative Type: _____

Representative Full Name: _____

Representative Phone Number: _____ Representative Email Address: _____

3. INSURANCE INFORMATION

Primary Insurance Payer:

Primary Insurance Policy Number:

Insurance Group Number:

Secondary Insurance Payer:

Secondary Insurance Policy Number:

Secondary Insurance Group Number:

Medicare Number:

Medicaid Number:

4. HEALTH AND MEDICAL INFORMATION

Client's Primary Diagnosis:

Client's Secondary Diagnosis:

Client's Current Medications:

Is the client on a special diet or restriction (i.e., low-sodium, cardiac diet, thickened liquids, mechanic soft)? Yes ☐ No ☐

Does the client have an advance directive? Yes ☐ No ☐

Does the client have a Do Not Resuscitate order? Yes ☐ No ☐

Is the Client currently under a doctor's order for home health and actively receiving home health services?
Yes ☐ No ☐ *If yes, please complete the following:*

Name of Home Health Agency:

Home Health Agency Telephone Number:

Has the client been certified by a physician as terminally ill and currently receiving hospice services?
Yes ☐ No ☐ *If yes, please complete the following:*

Name of Hospice Agency:

Hospice Agency Telephone Number:

Health History:

Reason for Referral:

Additional Comments:

5. HEALTH CARE PROVIDER INFORMATION

Health Care Provider's Name: _____ Practice Name: _____

Practice Address: _____

Practice Phone Number: _____ Practice Fax Number: _____ Practice Email Address: _____

6. CLIENT IMPAIRMENTS/LIMITATIONS

- ☐ Condition related to brain or spinal cord
- ☐ Condition related to cardiovascular system
- ☐ Condition related to respiratory system
- ☐ Condition related to urinary system/pelvic floor
- ☐ Catheter, ostomy, open drains
- ☐ Peripheral IV, Central Line, or Arterial Line
- ☐ Parenteral or enteral nutrition
- ☐ Tracheostomy
- ☐ Oxygen Therapy
- ☐ Orientation/memory/attention impairment
- ☐ Vision impairment
- ☐ Auditory impairment
- ☐ Sensory, touch, or proprioceptive impairment
- ☐ Incontinence
- ☐ Communication barriers (expressive or receptive)
- ☐ Immunocompromised
- ☐ Pain
- ☐ Shortness of breath
- ☐ Generalized weakness and fatigue
- ☐ Wound infection or non-healing wound
- ☐ Activity intolerance
- ☐ Open/draining wound
- ☐ Fall Risk
- ☐ Unsteady gait

- [ ] Non-weight or partial weight bearing
- [ ] Wheelchair bound requiring assistance
- [ ] Requires special transportation needs
- [ ] Requires aide of another person to safely leave home
- [ ] Requires use of assistive device (walker or cane)
- [ ] Home accessibility medical equipment required (Hoyer lift, overhead ceiling lift, etc.)
- [ ] Cognitive deficits impair judgement safe navigation and decision making
- [ ] Elopement Risk
- [ ] Sexually Acting Out Behaviors
- [ ] Aggressive Behaviors
- [ ] Self Harm/Harm to Others
- [ ] Assault Risk
- [ ] History of Seizures
- [ ] Aspiration Risk

7. REQUESTED SERVICES (Select All that Apply)

- [ ] Companionship
- [ ] Dementia/Alzheimer's Care
- [ ] Light Housekeeping
- [ ] Meal Preparation
- [ ] Medication Reminders
- [ ] Mobility & Transfer Assistance
- [ ] Nonskilled Respite Care
- [ ] Personal Care & Waste Management
- [ ] Sitter Services
- [ ] Transportation Assistance

8. REFERRAL SOURCE

Referring Agency/Facility Name:

_____

Referral Contact Name:

_____

Position/Title:

_____

Referral Contact Phone Number:

_____

Referral Contact Email Address:

_____