

# IN GOOD FAITH HOME CARE REFERRAL FORM

(800) 789-6005  
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:

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Primary Insurance Policy Number:

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Insurance Group Number:

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Secondary Insurance Payer:

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Secondary Insurance Policy Number:

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Secondary Insurance Group Number:

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Medicare Number:

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Medicaid Number:

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### 4. HEALTH AND MEDICAL INFORMATION

Client's Primary Diagnosis:

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Client's Secondary Diagnosis:

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Client's Current Medications:

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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:

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Home Health Agency Telephone Number:

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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:

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Hospice Agency Telephone Number:

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**Health History:**

Empty rectangular box for Health History.

**Reason for Referral:**

Empty rectangular box for Reason for Referral.



**Additional Comments:**

Empty rectangular box for 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:

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Referral Contact Name:

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Position/Title:

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Referral Contact Phone Number:

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Referral Contact Email Address:

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