ANCORA
Home Health & Hospice

Anchorage Office: 907-561-0700
Wasilla Office: 907-561-9240
Toll Free: 888-930-2090
FAX: 866-934-0349

HOME HEALTH REFERRAL/PHYSICIAN ORDERS

Patient Name: _____ **Date of Birth: _____**

Primary Physician*: _____ **Follow-Up Appt. Date/Time: _____**
*If referring MD is not following patient for Home Health.

Call for availability. Provider ordered start date: _____

RESUMPTION OF CARE? ☐ Yes ☐ No

INSURANCE: ☐ Medicare ☐ Medicaid ☐ Commercial ☐ Medicare Replacement ☐ Other

PLEASE ATTACH:

- Patient Demographics
- Most Recent SIGNED H+P
- D/C Summary or Visit Note
- Medication List
- Diagnosis List
- PICC Line Insertion Flow Sheet

HOME HEALTH ORDERS

SKILLED NURSING – DX/ICD-10 Code: _____
☐ Wound Care – NOTE: Include latest PT note signed by a MD OR complete page 2
☐ Diabetic - Date/Result of last A1C: _____ ☐ Cardiac ☐ CHF ☐ Respiratory ☐ Pneumonia ☐ COPD
☐ Pain ☐ Medication Management ☐ Labs ☐ IV Therapy ☐ Urinary Cath – Date of last insertion: _____
☐ Maintain dressing changes and care of the CVC, Implanted Port, PICC, etc. weekly or monthly as needed until receiving discharge order from physician.
☐ Alteplase 2 mg/2 mL IVP, MR times 1 per protocol to clear occluded CVC, Implanted Port, PICC.
☐ IV Access - PICC flush with 10 mL normal saline IV before and after each medication and at least every 12 hours when accessed. Flush weekly when not in use.

☐ HOME HEALTH AIDE -- Must be in addition to PT or SN; cannot stand alone

PHYSICAL THERAPY -- DX: _____
☐ Fall Risk ☐ HX of Falls ☐ Hip Fracture ☐ Joint Replacement: ☐ Hip ☐ Knee ☐ Other _____
☐ Transfer ☐ Gait Training ☐ Strengthening ☐ Balancing ☐ ROM ☐ CPM Needed ☐ Home Exercise Program
☐ Other: _____

OCCUPATIONAL THERAPY -- DX: _____
☐ ADLs ☐ Adaptive Devices ☐ Energy Conservation ☐ Cognition ☐ Low Vision ☐ Home Modification
☐ Other: _____

SPEECH THERAPY -- DX: _____
☐ Swallowing ☐ Cognition ☐ Language ☐ Aphasia ☐ Other: _____

SOCIAL WORKER -- DX: _____
☐ Coping Skills ☐ Safety ☐ Environment ☐ In-Home Needs ☐ Additional Resources ☐ Other: _____

ATTESTATION: I confirm that these ordered services for home health are based on findings gathered at a facility or my office during a face-to-face encounter with this patient.

Visit Performed By: _____ **Encounter Date: _____**

Physician Signature: _____ **Date: _____**

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WOUND CARE ORDERS

Wound Care Orders Continued from page 1

Patient Name: _____ Date of Birth: _____

To comply with Medicare regulations, wound care order must be completed and signed by a physician.

WOUND LOCATION: _____ DX CODE: _____

YOU MUST SELECT THE FOLLOWING TYPE:

TYPE: ❑ Trauma ❑ Surgical ❑ Venous Stasis ❑ Arterial ❑ Pressure ❑ Diabetic ❑ Other: _____

Current Wound Size (W/L/D) cm: _____

SN to perform wound care at each visit and educate caregiver as appropriate.

❑ Cleanse with normal saline - may apply skin prep peri wound. May apply alginate and/or OptiLock if moderate to heavy drainage. May also cover with bordered foam dressing. May change 2-3x per week. Once caregiver return demonstrates wound care, he/she may perform wound care on days SN does not visit.

❑ Wound Vac – cleanse wound and peri-wound with NS and pat dry. Apply skin prep to peri-wound, then cover with transparent drape create opening over wound. Lightly pack with Black Foam; may use White Foam for tunneling or undermining. Create opening in transparent drape and attach to wound vac tubing and set wound vac at 125 mmHg negative pressure. If wound vac becomes compromised, may remove and discard. Cleanse with NS, pack wound lightly with saline moistened gauze. Cover with ABD and secure with tape.

❑ OTHER - If preferred, please provide specific instructions below:

_____

_____

_____

SN to notify physician if assessment reveals a need for new recommendations/wound care orders.

Date patient last seen by physician: _____

Follow-up appointment date: _____

Physician Signature: _____ Date: _____