Request met by: _____
_____
Date: _____
T/C _____Visit _____

SCHOHARIE COUNTY DEPARTMENT OF HEALTH
PO BOX 667 SCHOHARIE COUNTY, N.Y. 12157
Phone (518)295-8474 Fax (518)295-8786

REFERRAL

Patient Name:_____ D.O.B._____
(Last) (First)
Home Address:_____ SS#_____
_____Medicare#_____
_____ Medicaid#_____
Telephone # ( )_____Other Ins._____
Temporay Address (if different)_____
Emergency Contact: _____Telephone _____
Alternate Contact:_____Telephone #_____
Hospital Admission Date:_____ Hosptial Discharge Date _____
Facility Name: _____ Attending Doctor:_____
PCP:_____ PCP# _____

THE FOLLOWING ITEMS ARE REQUIRED:

- Principal Diagnosis:_____
- Other Diagnoses Related To Need for PHN Services
  1. _____2._____
  3._____4._____
- Surgical Procedures & Dates
  1._____ (2)_____
  (Date) (Date)
- Allergies _____
- Special Diet _____
- MD Signing Home Care orders: _____
- MD Contact # _____

Check items attached
History [ ] Physical [ ] Discharge Medication List [ ]

Please indicate organism which caused any infection if known _____

(OVER)

NURSING SERVICES REQUESTED

ASSESS

( ) Cardiac status
( ) Neurological status
( ) Peripheral vascular status
( ) Diabetes management
( ) s/s of electrolyte imbalance
( ) Mental/emotional status
( ) Skin condition
( ) Bowel/bladder function
( ) Resolution of infection
( ) Post-op recovery & care
( ) Safety/home environment
( ) ADL's/ambulation capabilities/tolerance
( ) Wound care/dressings
( ) Foley catheter care
Date inserted_____
Catheter size_____
Lab work ordered:_____
_____

TEACH

( ) Medication routine
( ) Insulin administration
( ) Ostomy care
( ) Wound care
( ) Nutrition
( ) _____
( ) _____

Other services requested:
( ) PRI/SCREEN
( ) PT ( ) HHA ( ) PCA
( ) OT ( ) ST ( ) RD
( ) Adult protective
( ) DME's_____
_____
_____
Supplier:_____
_____

Other MD orders:_____

_____

_____

_____

INFORMATION DAY OF DISCHARGE

Lungs:_____ Heart:_____ Appetite_____
Bowel/bladder function:_____ Mental status:_____
Edema:_____ ADL/Ambulation status:_____
Wound, Ostomy/Drainage Tube location condition/size & care and type of dressing
(include frequency and equipment)_____

_____

Temp_____ Resp_____ B/P_____ Pulse_____
Weight_____ Last BM_____
Lab Values:_____
RN Signature_____Date_____

MD Signature_____ Date_____

Date_____Time_____am/pm Referral Source_____

Completed by:_____ Tel #_____