ROCHESTER REGIONAL HEALTH | LifetimeCare Home Health Care & Hospice

Patient Information

Requested Visit Date:_____

Last Name:_____ First Name:_____ M.I.:_____

Address:_____ City:_____ State:_____ Zip:_____

Phone:_____ D.O.B.:___/___/_____ Sex: ___M ___F Primary Language:_____

Emergency Contact:_____ Phone:_____

Insurance Carrier:_____ Policy #:_____

Primary Dx:_____(Medicare PDGM does not allow: signs/symptoms, abnormal/unsteady gait, falls, muscle weakness, generalized weakness, debility, joint pain, superficial injury/skin tear, or unspecified wound codes – the underlying cause must be stated)

Secondary Dx:_____

PLEASE CHECK ALL SERVICES YOU ARE REQUESTING FOR YOUR PATIENT

Nursing

- ☐ Evaluate for Home Care Service Need
- ☐ I.V. Therapy
- ☐ Medication Teaching
- ☐ Telemonitoring
- ☐ Enriched Care (palliative care; 1yr or less prognosis)
- ☐ Hospice_____
- ☐ Other_____

Physical Therapy **

- ☐ Evaluation & Treatment
- ☐ Home Safety
- ☐ Falls Prevention
- ☐ Strength & Conditioning
- ☐ Equipment Ordering & Teaching
- ☐ Neurological Rehabilitation
- ☐ Other_____

Evaluation for other services **

- ☐ Home Health Aide
- ☐ Occupational Therapy
- ☐ Social Work
- ☐ Speech/Language
- ☐ Medication Teaching
- ☐ Other_____

☐ **** These services also require a Nursing Evaluation**

Lifetime Care is committed to personalized treatment to meet each patient's specific medical needs. Please check any of the following programs your patient may require.

- ☐ Cancer Care
- ☐ Diabetes Education/Care
- ☐ Parkinson's Disease Care
- ☐ Women & Children's Health
- ☐ Wound Care Specific wound care orders _____
- ☐ Cardiopulmonary Care
- ☐ Orthopedic Prescreen (Home visit prior to surgery)
- ☐ Pediatric Palliative Care

PLEASE FAX CURRENT MEDICATION LIST AND INCLUDE ALL DIAGNOSES.

Physicians' Original Signature:_____ Date:_____

Print Name:_____ Phone Number:_____

Please fax this completed form to: (585) 214.1039

Phone: (585) 214.1000 RochesterRegional.org/LifetimeCare