WILSHIRE
HOME HEALTH

Physician/Facility Referral

Patient Name: ______________________________ MD/Facility: ______________________________

Please attach demographics OR complete: Contact Name: ______________________________

Address: ______________________________ MD Phone #: ______________________________

______________________________ MD Fax #: ______________________________

Phone #: ______________________________ Alternate #: ______________________________

Insurance: ☐ Medicare ☐ Medi-Cal ☐ Other

ID#______________________________ Patient Emergency #: ______________________________

DOB: ______________ SS# ______________________ **Admitting Diagnosis** ______________________________

Telehealth units will be included with diagnosis of: COPD, CHF, DM, Renal Disease, Pneumonia and Palliative Patients

Skilled Nursing	**Palliative Care**	**Physical Therapy**	**Speech Therapy**	**Occupational Therapy**
Assess & Instruct For:	**Assess & Instruct For:**	**Evaluate & Treat For:**	**Evaluate & Treat For:**	**Evaluate & Treat For:**
☐ Medication Mgmt. ☐ Pain ☐ Cardiac ☐ Diabetic Mgmt. ☐ Respiratory ☐ Wound ☐ IV ☐ **Telehealth** ☐ Other	☐ Pain ☐ Shortness of Breath ☐ Constipation ☐ Emesis/Nausea ☐ Psychosocial** ☐ Music Therapy** ☐ Chaplain ** ☐ Dietician** ****Must accompany skilled nursing****	☐ Weakness ☐ Ambulation/Gait Training ☐ Transfers ☐ Balance ☐ Fall Risk/Injury ☐ Range of Motion ☐ WBS	☐ Swallowing ☐ Impaired Cognition ☐ Dysphasia ☐ Dysphagia ☐ Alternate Communication/Need ☐ Other	☐ Safety Training ☐ Adaptive Equipment ☐ Cognitive Training ☐ ADL Retraining **Additional Services Needed:** ☐ MSW ☐ Home Health Aide ☐ **Telehealth** ☐ Dietician

Wound Orders:

Cleanse With: ______________________________ Apply: ______________________________

Secure: ______________________________ Frequency: ______________________________

Date of Face-to-face encounter: I certify that this patient is under my care and that I, my nurse practitioner or physician's assistant, had a face-to-face encounter on ______________________.

Please attach and fax these essentials:

Demographics ◆ Insurance Information ◆ History & Physical◆ last Visit Notes

Physician's Signature: ______________________________ Date: ______________________

FAX To: (805) 782-8612 ◆ Telephone: (805) 782-8600