REFERRAL SOURCE:

OMNI PARK HOME CARE

Caring Is Our Mission……..

Referral Date:

CORPORATE OFFICE

Omni Park Health Care
27801 Euclid Avenue, Suite 600
Euclid, Ohio 44132

Office: (216) 289-8963
Fax 1: (216) 289-9114

Toll Free: 1-800-988-8104
www.OmniParkHealthCare.com

PATIENT INFORMATION

Last Name	**First Name**	
Address		
City	**State**	**Zip Code**
Telephone Number ( )	**Sex** ❑ Female ❑ Male	
Date of Birth	**Social Security Number**	
Family Contact/Relationship	**Telephone Number** ( )	

PHYSICIAN INFORMATION

Physician Name	**License**	**Telephone Number** ( )	
Address	**City**	**State**	**Zip Code**
Fax Number ( )	**Requested Visit Date**	**Office Contact**	
Physician Signature	**NPI**	**UPIN**	

DIAGNOSIS

PRIMARY DIAGNOSIS

REASON FOR HOME CARE/ORDERS
(DETAILED SKILLED NEEDS FOR MANAGED CARE AUTHORIZATION)

_____

_____

DIABETES ❑ TYPE 1 ❑ TYPE 2

❑ Teach diabetic mgmt./self-care ❑ Teach glucose monitoring
❑ Contact MD if blood glucose above _____ or below _____

❑ Current HbA1c _____ Current glucose _____
❑ Provide special adaptive devices

CARDIOVASCULAR DISORDERS

❑ Educate on signs & symptoms of CHF, MI, CAD, A. Fib, HTN
❑ Assess cardiac status
❑ Daily weight recording
❑ Current Weight
❑ Contact MD for BP systolic above _____ or below _____
diastolic above _____ or below _____
❑ Apical pulse above _____ or below _____

SECONDARY DIAGNOSIS

MEDICATIONS/DOSE/FREQ./ROUTE

_____

MEDICATIONS/DIET CHANGES

❑ Teach medication and adherence with new/old regimens
❑ Teach nutrition ❑ Diet

ASTHMA/COPD

❑ Educate on disease management ❑ Assess home for triggers
❑ Educate in use of nebulizers/inhalers

GENERAL ISSUES

❑ Clinical/environmental assessment needed ❑ Pain management
❑ Provide short-term counseling ❑ Provide long term care planning

OTHER TREATMENT

_____

_____

_____

SKILLED SERVICES

❑ RN ❑ PT ❑ OT ❑ ST ❑ HHA

GAIT ABNORMALITY

❑ Evaluate home safety ❑ Assess equipment needs

INSURANCE INFORMATION

Buckeye Id ❑ OK ❑Not OK	**CareSource Id** ❑ OK ❑Not OK	**Wellcare Id** ❑ OK ❑Not OK
Home Choice ❑ OK ❑Not OK	**Medicaid Number / Ohio Home Care Waiver** ❑ OK ❑Not OK	**Medicare Number** ❑ OK ❑Not OK
MRDD ❑ OK ❑Not OK	**Veterans Affairs** ❑ OK ❑Not OK	**VA** ❑ OK ❑Not OK

INTERNAL USE ONLY ❑ REFERRAL COMPLETE ❑ INCOMPLETE ❑ CALL BACK REQUIRED