Westminster Canterbury AT HOME

REQUEST FOR HOME HEALTH SERVICES

Phone: **(757) 496-1653** | *Fax:* **(757) 496-1771**
Email: homecare@wcbay.com | www.wcathome.com

Today's date: _____/_____/_____

PATIENT INFORMATION

Last Name	First Name	Middle	SSN

Street Address	City	State	Zip	DOB

Home Phone	Cell Phone	Email	Gender ❑ M or ❑ F

Insurance ❑ Medicare ❑ Other _____	Medicare / Policy #

Last MD Office Visit Date	Emergency Contact Name	Emergency Contact Phone

Primary Diagnosis / Secondary Diagnosis	DME Equipment Needed ❑ Yes or ❑ No	Type of DME

PHYSICIAN'S ORDER

- ❑ SKILLED NURSING - *Evaluate and Treat*
- ❑ PHYSICAL THERAPY - *Evaluate and Treat*
- ❑ OCCUPATIONAL THERAPY - *Evaluate and Treat*
- ❑ SPEECH THERAPY - *Evaluate and Treat*
- ❑ MEDICAL SOCIAL WORK
- ❑ HOME HEALTH AIDE

SPECIALTY PROGRAMS

- ❑ CHF ❑ COPD ❑ STROKE
- ❑ CATHETER CARE
- ❑ POST-SURGICAL CARE
- ❑ WOUND CARE
- ❑ DIABETIC CARE
- ❑ OSTOMY CARE

PHYSICIAN INFORMATION

Contact Name at Physician's Office	Office Phone	Office Fax

Referring Physician's Name

Referring Physician's Signature	Date

****Please include H&P, current office visit note that supports the primary diagnosis for home health services, copy of insurance card, and medication list with this referral form when faxing to our office. Thank you!**