Home Health

Please call (800) 940-5151 before faxing to ensure delivery.
Fax: (800) 676-3127

PLEASE ATTACH DEMOGRAPHICS AND SUBSCRIBER'S INSURANCE CARD/INFORMATION.

Patient Name: _____

Diagnosis: _____

Surgical Procedure: _____

Ordering Physician: _____

Phone: ( ) _____

Contact Person: _____

Phone: ( ) _____

Start of Care: _____

- ❑ R.N. Eval and TX
- ❑ P.T. Eval and TX
- ❑ O.T. Eval and TX
- ❑ S.T. Eval and TX
- ❑ MSW (not covered by all policies)

Specific Instructions: _____

_____

Labs Ordered: _____

_____

❑ R.N. for Wound Care

Wound Care Orders: _____

_____

Physician's Signature: _____ Date: _____

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BC080585-1008

BayCare HomeCare

Managed Care Office
8452 118th Ave. N.
Largo, FL 33773

Infusion Therapy

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Patient Name: _____

Diagnosis: _____

Surgical Procedure: _____

Ordering Physician: _____

Phone: ( ) _____

Type of Medication/Dose/Frequency:

Rx: _____

Duration Rx: _____

Next Dose Due: _____

Please attach a specific Rx for TPN Formula.

Allergies: _____

Height: _____ Weight: _____

❑ HHC to insert PIV or Midline

Type of Line: ❑ PICC ❑ Groshong ❑ PIV ❑ Port ❑ Other: _____

Number of Lumens: _____

Has the patient had this IV medication before? ❑ Yes ❑ No
❑ If no, please order ANA kit.

Labs Ordered: _____

_____

Physician's Signature: _____ Date: _____

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Non-Respiratory DME

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Patient Name: _____ Date of Birth: _____

Diagnosis: _____

Ordering Physician: _____ Phone: ( ) _____

Contact Person: _____ Phone: ( ) _____

Patient's Height: _____ Weight: _____

Subscriber's Name: _____ Subscriber's Date of Birth: _____

Subscriber's Social Security Number: _____

Emergency Contact: _____ Phone: ( ) _____

Standard wheelchair: ❑ Yes ❑ No
with ELRs ❑

Lightweight wheelchair: ❑ Yes ❑ No
with ELRs ❑

Commode: ❑ Yes ❑ No
Extra wide: ❑ Yes ❑ No
Standard: ❑ Yes ❑ No

Standard walker: ❑ Yes ❑ No

Walker with wheels: ❑ Yes ❑ No

Platform attachment: ❑ Yes ❑ No

Hospital bed: ❑ Yes ❑ No

Other: _____

_____

_____

A Rx should accompany each order.

Physician's Signature: _____ Date: _____

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Phototherapy Referral

Please call (800) 940-5151 before faxing to ensure delivery.
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Patient Name: _____ Date of Birth: _____

Gestational Age: _____ Length: _____ Weight: _____

Parent's Name: Mother: _____ Father: _____

Mother's DOB: _____ Father's DOB: _____

Address (incl. apt. #): _____

City: _____ State: _____ Zip: _____

Home Phone: ( ) _____ Cell or Work Phone: ( ) _____

Emergency Contact: _____ Phone: ( ) _____

PLEASE ATTACH INSURANCE INFORMATION

Diagnosis: ❑ Hyperbilirubinemia ❑ Other: _____

Is infant COOMB'S Positive? ❑ Yes ❑ No

Current Total Bilirubin Level: _____ When Drawn? _____

Ordering Physician: _____ Phone: ( ) _____

Address: _____

Report Bili Levels to: _____ Phone/pager: ( ) _____

PHOTOTHERAPY ORDERS (CHOOSE ONE):

❑ Single Phototherapy with suitcase ❑ Single Phototherapy with blanket ❑ Double Phototherapy

HOME HEALTH ORDERS:

❑ R.N. to teach/train Phototherapy set-up ❑ No nursing needed (see below*)

LAB ORDERS:

❑ Total Bili Level ❑ Direct Bili Level ❑ HGB/HCT ❑ CBC

❑ R.N. to Draw ❑ Levels to be drawn in M.D. office ❑ Levels to be drawn in Outpatient Lab

Above orders to be repeated daily until infant is discharged from Home Health.

** If no nursing follow-up is ordered, by checking this box, the physician is signifying that patient's Bili level is below 19, and physician is aware that there will be no nursing follow-up after initial call by MCO Triage or Specialty Nursing Triage to verify equipment was delivered and set up.*

Physician's Signature: _____ Date: _____

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