

PATIENT: LAST NAME FIRST NAME		TO: UNITED HOME HEALTH SERVICES, INC. 2200 CANTON CENTER ROAD, SUITE 250 CANTON, MI 48187 PHONE (734) 981-8820 FAX: (734) 981-8828 www.uhhs.org	
ADDRESS FOR CARE CITY OR TWP.		FROM: (Please fill in your name/address/phone)	
PHONE:		REFERRAL DATE: <input type="checkbox"/> AGENCY 1ST VISIT <input type="checkbox"/> REPORTED BY:	
PATIENT'S ADDRESS, if not same as above PHONE		REPORTED TO:	
COMPLETE DATE OF BIRTH SEX MARITAL STATUS		DATE:	
M F S M W D Sep		SS#:	
RESPONSIBLE RELATIVE OR FRIEND		MEDICARE NO.	
RELATIONSHIP: PHONE: (H) (W)		MEDICAID NO.	
		BLUE CROSS NO. OR OTHER INS: (Give Name)	

REPORT OF MEDICAL FINDINGS

PRIMARY DIAGNOSIS (Include Date of Onset):	BRIEF MEDICAL HISTORY
SECONDARY DIAGNOSIS:	RECENT HOSPITALIZATION:
SURGERY PERFORMED (Type and Date):	DATE AND PLACE OF PHYSICIAN'S NEXT VISIT: <input type="checkbox"/> HOME <input type="checkbox"/> OFFICE <input type="checkbox"/> CLINIC

MEDICAL ORDERS AND PLAN OF TREATMENT

DIET:

DRESSINGS OR TREATMENT:

MEDICATIONS:

ALLERGIES:

FLU VACCINE NO YES DATE _____

PNEUMONIA VACCINE NO YES DATE _____

LABORATORY ORDERS:

ACTIVITY ALLOWANCE:

EQUIPMENT: Prostheses Brace Walker Wheelchair Cane Bed B.S. Commode Other _____

DISCIPLINES ORDERED: RN PT OT SW ST HHA Reg. Dietitian ET RN Psych RN

I certify that the above patient is under my care and requires the above Home Health Services because he is confined to his home. These professional services are to be provided on an intermittent basis and the established plan contained in the record will be reviewed by me at least every two months. These services are needed to treat all of the conditions for which the patient was treated during the related in-patient hospital or post-hospital extended care facility approved stay.

DATE	PHYSICIAN'S SIGNATURE	ADDRESS	PHONE
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PATIENT NAME:

PATIENT ASSESSMENT

ACTIVITY LIMITATIONS:

- Ambulatory
- Ambulatory with assistance
- Confined to Bed Chair

ACTIVITIES OF DAILY LIVING:

- Independent
- Needs Assistance
- Unable to do

VITAL SIGNS WITH RANGES & DATES:

- TPR
- BP
- WT
- HT

MENTAL STATE:

- Alert Depressed
- Apathetic Disoriented
- Confused
- Other _____

INCONTINENCE:

- | | | | |
|---------|--------------------------|--------------------------|--------------------------|
| | None | Partial | Complete |
| Bowel | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Bladder | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

DIAGNOSTICS:

DISABILITIES AND IMPAIRMENTS:

- | | |
|------------------------------------|---------------------------------------|
| Mentality <input type="checkbox"/> | Amputation <input type="checkbox"/> |
| Speech <input type="checkbox"/> | Paralysis <input type="checkbox"/> |
| Hearing <input type="checkbox"/> | Contractures <input type="checkbox"/> |
| Vision <input type="checkbox"/> | Decubiti <input type="checkbox"/> |
| Sensation <input type="checkbox"/> | |

LABORATORY:

- | | |
|----------|----------------|
| Hgb | Na |
| RBC | K ⁺ |
| Hct | Cl |
| WBC | CO2 |
| PLT | BUN |
| Glucose | Creatinine |
| Cultures | Albumin |

DIAGRAM TO SHOW LOCATION, SIZE, EXTENT, ETC., OF WOUND, STOMA, BURN, DECUBITI, GRAFT OR OTHER AFFECTED AREA:

OTHER SIGNIFICANT FINDINGS:

ADDITIONAL COMMENTS:

PRIMARY CARE PHYSICIAN:

OTHER PHYSICIANS:

SIGNATURE _____

TITLE _____ DATE _____