Oceanside
HOME HEALTH SERVICES, INC.

4322 Wilshire Blvd., Suite 208, Los Angeles, CA 90010
Telephone: (323) 934-5050 FAX: (323) 934-9850

REFERRAL INTAKE

PATIENT'S NAME:		AGE:	MR#:
Start of Care (SOC) Date:		D.O.B:	SEX: ☐ Male ☐ Female
Address: City: State: CA Zip Code: Telephone #:		Medicare#: SS#: MEDI-CAL#: Issued:	
Language(s) Spoken:	Race:	HIC Verified By: _____ []OK [] NIF [] HMO	
Emergency Contact/Responsible Party:		Other Payor Source:	
		Insurance Group#:	
Emerg Cont Phone#:	Relationship:	Insurance Telephone#:	
Address:		Referral Source:	
City: State: CA Zip Code:		Referral Given By:	
Primary MD:		Second MD:	
UPIN#:	License #:	UPIN #:	License #:
Telephone#:	FAX #:	Telephone#:	FAX#:
Address:		Address:	
City: State: CA Zip Code:		City:	State: CA Zip:
Latest Hospitalization From:	To:	Skilled Nsg Facility: From:	To:
Hospital Name:		SNF:	
Last MD Visit:		Allergies: []PCN []Codeine []Aspirin [] Others: _____	
DIAGNOSIS: ONSET 1. _____ _____ 2. _____ _____ 3.			
Surgical Procedure:	Date:	CASE ASSIGNED TO:	DATE
PHYSICIAN'S INITIAL ORDERS: SN to do evaluation for Home Health Care.		SN _____ _____ SN _____ _____ CHHA _____ _____ PT _____ _____ OT _____ _____ MSW NOTES:	
PT/Family notified of initial visits: Date/Time: _____ By: _____		SUPPLIES:	
VERIFIED EVAL. ORDER PER DR. REFERRAL DATE:		By:	