THE ROYAL CARE
HOME HEALTH CARE SERVICES

6323 14th Avenue,Brooklyn, NY 11219 - Tel: 718-851-3800 Fax: 718-228-5386
E-mail: Intake@rchomecare.com

From _____

Phone # _____

Fax # _____

Email: _____

PHYSICIAN SIGNING HOME CARE ORDERS

PHYSICIAN NAME

ADDRESS

TELEPHONE # FAX#

NPI # LICENSE #

Reason for Home Care

DIAGNOSIS (Indicate * if a new diagnosis):

1.

2.

3.

ALLERGIES:

MEDICATIONS / DOSE / FREQUENCY / ROUTE:

DIABETES: ☐ **TYPE 1** ☐ **TYPE 2** ☐ **GESTATIONAL**

☐ Teach diabetic manager / self care

☐ Teach glucose monitoring

☐ Contact MD If blood glucose is above _____ or below _____

☐ Diet _____

CARDIOVASCULAR DISORDERS:

☐ Educate on signs and 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_____

Diet _____

DOCTORS TREATMENT / ORDERS:

MD Signature _____ **Date** _____

PATIENT INFORMATION

LAST NAME FIRST NAME

SEX ☐ Male ☐ Female TELEPHONE #

ADDRESS APT #

CITY STATE ZIP

DATE OF BIRTH SOCIAL SECURITY #

LIVES WITH ☐ Family ☐ Alone ☐ Caregiver

ETHNICITY LANGUAGE SPOKEN BY PATIENT

MENTAL HEALTH STATUS; Is the patient ☐ Yes

☐ Oriented ☐ Forgetful ☐ Confused self-directing? ☐ No

FAMILY CONTACT / RELATIONSHIP (MUST PROVIDE FOR PRI)

CONTACT TELEPHONE #

Day Evening

MEDICARE # MEDICAID #

COMMERCIAL INSURANCE CARRIER (NAME & AUTHORIZATION #)

SUBSCRIBER

POLICY # GROUP #

Reason for Home Care Continued

WOUNDS:

☐ 2, 3 day supply given to patient

☐ Pressure ☐ Venous ☐ Arterial ☐ Diabetic ☐ Other

Location _____

Stage & size of wound _____

WOUND CARE:

☐ Hydrogel ☐ Ca-Alginate ☐ Hydrocolloid ☐ NS wet to damp

☐ Other _____

Frequency: ☐ 3-5 wk ☐ 1-2wk ☐ Daily ☐ Other

GAIT / AMBULATORY STATUS: ☐ Homebound

☐ Unassisted ☐ Assistive device _____

☐ Evaluate home safety ☐ Assess equipment needs ☐ Yes

Did patient have a Rehab Hospital/Unit admission within the last 10 days? ☐ No

SKILLED SERVICES: Frequency: _____ times per week for _____ weeks

☐ RN ☐ PT ☐ OT ☐ ST ☐ MSW ☐ HHA

LAB REQUEST:

☐ Albumin ☐ SMAC ☐ CBC w/diff ☐ PT/INR ☐ HbA1c

☐ Other _____

☐ Frequency _____

MEDICATIONS / DIET CHANGES:

☐ Teach medication and adherence with new/old regimens

☐ Teach nutrition ☐ Diet _____

ASTHMA / COPD: ☐ Assess home for triggers

☐ Educate on disease management ☐ Peak Flow Meter

☐ Educate on use of nebulizers/inhalers ☐ Educate O2 precautions