REFERRAL FORM

Crossroads Home Care Inc.

_____NEW _____RE-ADMIT _____REFERRAL SOURCE_____ Contract_____ Other_____ DATE_____ TIME:_____

Person Inquiring:

Name;_____

Relationship:_____

Phone: _____

Address:_____

_____

How did you hear about us?

_____

Primary Language of Patient:
English Spanish Other(list)_____

Interpreter Name:_____
Interpreter Phone: _____

Participant/Client:
PAYMENT SOURCE:
___Private Pay ____ Insurance (LIST)_____
___ Contract: (circle all that apply) AIHS HPE VA R2 R3C CareWell, Other_____

Name: _____DOB ___/___/___

Address:_____
_____

Phone: _____ SOC: _____-_____-_____

Marital status: M S W D SEP SIGNIFICANT OTHER UNKNOWN
Other Services: DME/Other Agency/Other Services received_____
Narcotics, Medical Marijuana or illegal drugs in home:_____

ADL's: Ind Dep With help
Allergies:_____

Advance Directives: YES NO
POA Living Will Guardian DNR Health Care Surrogate

Physicians Name_____Phone_____

Diagnosis:	Date of Onset:	Recurrence:	ICD-10 CODE
_____	_____	_____	_____
_____	_____	_____	_____
Equipment used in the home: Hoyer lift, Sara Lift, Other lift_____ , walker, cane, crutches, wheelchair, bed, risers, colostomy, OTHER:_____	_____	_____	_____
Details:_____	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

Discipline Requested	Frequency & Duration	Normal Billing Rate	Negotiated Rate
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Emergency Contact (Relationship):	Emergency Contact Address:	Emergency Contact Phone #:
Family Support (Relationship)	Family Support Address:	Family Support Phone #

Billing name & Address (If Different):

_____
_____

Insurance/Payer Case Manager/Claims Rep: _____PH# _____

Name of Carrier: _____Policy Holder Name:_____
Policy # _____Group/ID #_____ Effective Date:_____/_____/_____
Coding System required (ICD, CPT)_____, Invoicing System required (1500, other)_____

Remarks: Clinical Findings, Needs, Etc.

_____

Signature of Preparer:_____ Date:_____

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PARTICIPANT ILLNESS QUESTIONAIRE

YES NO Have you or anyone you have been around traveled within the last 14 days to other countries?
YES NO Are you or anyone you have been in contact with under investigation for COVID-19 (Coronavirus), or are you ill with respiratory illness?
YES NO Have you been ill in the last 14 days?
YES NO Nausea/Vomiting/Diarrhea (Circle all that apply)?
YES NO Fever/Sore Throat?
YES NO Persistent cough, sneezing, runny nose?
YES NO Flu or flu-like symptoms?
YES NO Did you go to the Doctors? When?_____
Date you became ill _____
YES NO Does the Participant/Client reside in a community where community-based spread of COVID-19 or any other reportable illness is occurring.

PARTICIPANT/CLIENT TB QUESTIONAIRE

This questionnaire is to be completed at the time of referral/pre-admission (Referral source, client and/or designated legal representative may answer)

TB HISTORY:

YES NO 1. Have you ever tested positive for TB infection?
- i. If no, complete risk assessment
- ii. If yes, ask have you ever been treated for Latent TB infection (LTBI)?

YES NO N/A
YES NO N/A iii. If yes, did you complete treatment for LTBI?

YES NO 2. Have you ever been diagnosed with having TB disease?
YES NO N/A i. If yes, were you treated for TB disease?
YES NO N/A ii. If yes, did you complete treatment for the disease?

Request medical records for any yes answers and any no answer to questions 1. a. ii, b. i, or b. ii, and complete SYMPTOM SCREEN BELOW:

RISK ASSESSMENT:

Ask the participant/client the following questions:

YES NO Have you worked or lived with or spent time with or been exposed to anyone in last two years who has been exposed to anyone who has been sick with TB in the last two (2) years?
YES NO Have you lived or traveled in Africa, Western Europe, Russia, Mexico, Central or South America, Asia, India, or the Philippine's within the last two (2) years?
YES NO Have you loved or worked in a correctional facility, long-term care facility, or homeless shelter?
YES NO Are you infected with any blood borne pathogens or have any specialized \ Infection Control needs (Strict Universal Precautions)?
YES NO Have you ever injected illegal drugs?
YES NO Do you smoke?

If the participant/client answers no to all the above questions, admit the participant/client.

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If the participant/client answers yes to any of the RISK ASSESSMENT questions, conduct a SYMPTOM SCREEN (BELOW).

SYMPTOM SCREEN:
Ask the participant/client, "Do you currently have any of the following symptoms?

YES NO Have you had a persistent cough and fever for more than three weeks?
YES NO Have you had loss of appetite for more than three weeks?
YES NO Have you been coughing up or spitting up bloody sputum (saliva)?
YES NO Is body weight 10% below ideal body weight?

YES NO Unexplained weight loss?
YES NO Have you had or currently have Drenching night sweats?
YES NO Have you had any Hoarseness?
YES NO Have you been having chronic chest pain?

If pt/client answers YES to 2 or more of the above questions- Notify appropriate management staff, VP/Administrator and/or President/Nursing Supervisor.

If the person answers "yes" to tow or more of the above symptoms, isolate the person as best is possible in their place of residence and provide or refer the person to his/her personal physician, private clinic or the local health department for TB testing (if the person has never had a positive TB test), medical evaluation, treatment and documentation of a non-infectious state, prior to admission.

YES NO N/A Referral source notified
YES NO N/A Referral/Notification made to Physician: Dr. _____

If the person answers "no" to all the above, admit the participant/client.

YES NO Mask worn on contact with our employee
YES NO Physicians/Contractor notified

Before Participant/Client Start of Care and or continuation of services, assure the following have been completed:

YES NO Has the pt/client had a complete medical exam?
YES NO Has the pt/client had a Mantoux or PPD TB skin test? (Obtain results for our records)
YES NO Has the pt/client had a chest x-ray? (Obtain results for our records)
YES NO Has the pt/client had a bacteriological exam (smear and culture)? (Obtain results for our records)

_____ _____
Signature of Administrative Representative completing form Date

Under CDC guidelines, persons who have latent TB infection (LTBI) and persons who are being treated for TB disease, but have documentation they are not contagious must not be refused treatment. These persons must be provided or referred to their physician, clinic or health department for treatment. This agency must monitor satisfactory compliance with and completion of TB and LTBI treatment regimens of employees and active patients under its care.