



Medicare • Insurance
Medicaid • CBA • PHC



American Home Care

Home Care Orders

Terrell
972-524-5800
972-524-9200 (fax)
1-866-290-4USA

Rockwall
972-771-4500
972-771-4288 (fax)
1-866-257-4USA

Mesquite
972-686-6447
972-686-6485 (fax)
1-866-295-4USA

Emory
903-473-4401
903-473-4403 (fax)
1-866-900-4USA

Patient Name: _____ Date of Birth _____

Address: _____

Phone: _____ Sex: Male Female

Next of kin emergency: _____
Name Phone #

Medicare # _____ Social Security # _____

Insurance: _____
Company Name / Address / Phone Policy / Group #

Primary Dx / Reason for home care: _____

Other Diagnosis: _____

Home Care Evaluation

- | | |
|---|---|
| <input type="checkbox"/> Home Health Evaluation | <input type="checkbox"/> Physical Therapy |
| <input type="checkbox"/> Home Safety Evaluation | <input type="checkbox"/> Occupational Therapy |
| <input type="checkbox"/> Nutrition Education | <input type="checkbox"/> Speech Therapy |
| <input type="checkbox"/> Skilled Nursing | <input type="checkbox"/> Home Health Aide |
| <input type="checkbox"/> Psychiatric Nursing | <input type="checkbox"/> Social Worker |

Physician Instruction and other comments: _____

Wound Evaluation

- | | |
|-------------------------------------|------------------------------------|
| <input type="checkbox"/> Wound Care | <input type="checkbox"/> Wound Vac |
|-------------------------------------|------------------------------------|

Physician Instruction and other comments: _____

Lab

- | | | | | | |
|---------------------------------------|------------------------------|------------------------------|---------------------------------|---------------------------------|--|
| <input type="checkbox"/> CBC | <input type="checkbox"/> CMP | <input type="checkbox"/> TSH | <input type="checkbox"/> HgbA1C | <input type="checkbox"/> PT/INR | <input type="checkbox"/> Fasting Lipid Profile |
| <input type="checkbox"/> Other: _____ | | | | | |

Instructions / Frequency: _____

DME Evaluation

- | | | |
|---|--|---|
| <input type="checkbox"/> Single Tip Cane | <input type="checkbox"/> Standard Wheelchair | <input type="checkbox"/> Alternating Air Mattress |
| <input type="checkbox"/> Quad Cane | <input type="checkbox"/> Heavy Duty Wheelchair | <input type="checkbox"/> Gel Overlay |
| <input type="checkbox"/> Hemi Walker | <input type="checkbox"/> Power Chair | <input type="checkbox"/> Nebulizer |
| <input type="checkbox"/> Junior Walker | <input type="checkbox"/> Scooter | <input type="checkbox"/> Oxygen |
| <input type="checkbox"/> Adult Walker | <input type="checkbox"/> Hospital Bed | O ₂ Concentrator/Gas@____LPM____Continuous |
| <input type="checkbox"/> Walker w/wheels & breaks | <input type="checkbox"/> Lift Chair | _____ % of Saturation Date _____ |
| <input type="checkbox"/> Light Weight Wheelchair | <input type="checkbox"/> Bedside Commode | |

Referring Physician: _____

Address: _____

Telephone: _____

UPIN: _____

(Physician Signature)