Ohana Pediatric
HOME HEALTH LLC
Ohana means family...family means no one is left behind.

REFERRAL INTAKE FORM
All Faxes to: 210-451-8554
Contact Phones:
San Antonio 210-451-8555
Dallas 214-774-9276
Austin 512-517-0260

Client Name:	M/F:	Date of Birth:
Client Address (Street #) (Apt #)	City, State	Zip Code
Name of Parent/Guardian:	Ph#:	Work/ Alt Ph#:
Social Service/Case Manager Name: (if applicable)	Ph#:	Fax Ph#:

Primary Language: ☐ English ☐ Spanish ☐ Other

Patient Availability: ☐ Day Time ☐ Afterschool ☐ No Preference

Medicaid#: _____ Other Insurance? ☐ YES ☐ NO IF YES, Name of Insurance:_____

Policy Holder's First/Last Name: _____ Policy Holder's Date of Birth:_____/_____/_____

Insurance Policy#:_____ Insurance Group#:_____ Ph#:_____

Diagnosis & ICD-10: _____ Onset Date: _____/____/_____

Diagnosis & ICD-10: _____ Onset Date: _____/____/_____

Please list any additional Orders/Treatment Instructions/Precautions/Diagnosis or instructions here:

Physician's Name:	Physician's Specialty:	Clinic Name:
Date Last Seen By Physician:	Most Recent Hospitalization Hospital : Diagnosis : Admit Date: Discharge Date:	Allergies:
Physician's Address (Street#) (Suite#)	City, State	Zip Code

Physician's Ph#:	Physician's Fax#:	Physician's Billing NPI#:	Physician's License/TPI#:

PEDIATRIC HOME HEALTH ORDERS:

Evaluation and treatment to be provided upon therapist availability and in accordance with insurance authorization and agency policy regarding evaluation and initiation of treatment.

_____**Private Duty Nursing Assessment:** PDN services may begin per agency initiation of services policy
_____**Speech Therapy Evaluation/TX 1-4 x week:** To evaluate patient within 30 days of agency's receipt of signed MD Orders OR agency's receipt of initial evaluation authorization, if required. Treatment is approved up to 4x per week OR as specified by signed therapy plan of care to begin within 30 days of receipt of payer authorization.
_____**Occupational Therapy Evaluation/TX 1-4 x week:** To evaluate patient within 30 days of agency's receipt of signed MD Orders OR agency's receipt of initial evaluation authorization, if required. Treatment is approved up to 4x per week OR as specified by signed therapy plan of care to begin within 30 days of receipt of payer authorization.
_____**Physical Therapy Evaluation/TX 1-4 x week:** To evaluate patient within 30 days of agency's receipt of signed MD Orders OR agency's receipt of initial evaluation authorization, if required. Treatment is approved up to 4x per week OR as specified by signed therapy plan of care to begin within 30 days of receipt of payer authorization.

Authorizing Physician Signature & Date:

Referral Source Name:	Referral Source Ph#:	Referral Source Fax#:
Referral Taken by Name & Title:	Referral Date:	How did you hear about us?