THE HSC HEALTH CARE SYSTEM
Health Services for Children with Special Needs, Inc. (HSCSN/NET)

HSCSN Home Care Referral Form

☐ **Initial Request** ☐ **Change in Request**

Instructions: Please complete the information and fax to HSCSN at 202-721-7190

I. PATIENT INFORMATION

Member Name:		Sex: ☐ M ☐ F	
Member ID:	Date of Birth:	Height:	Weight:
Primary Diagnosis :			
Treating Diagnosis/ICD 9 Code for Home Care:			

II. HOME CARE ORDER – to be completed by a MD or NP

☐ Visit for Assessment and Recommendations
☐ PT ☐ OT ☐ ST ☐ RN ☐ SW

☐ Skilled Nurse Hours/Day _____ **#of Days/Wk**_____
Dates of Service: _____ to _____
To: _____
_____
_____

☐ PCA/ HHA Hours/Day _____ **#of Days/Wk**_____
Dates of Service: _____ to _____
To: _____
_____
_____

III. CERTIFICATE of MEDICAL NECESSITY (Check all that apply) – to be completed by MD or NP

Respiratory/Cardiac Status
☐ Ventilator: Yes ☐ No ☐
☐ O_2 Route_____
☐ Pulse ox
☐ Apnea Monitor
☐ Suctioning Oral_____ Deep ____
☐ Trach
☐ Aspiration/Reflux precautions
☐ Other _____
_____

Nutrition
☐ Tube Feeding G-tube___ J-tube___
☐ Continuous Day___ Overnight ____
☐ Bolus - frequency_____
Elimination/Skin Care
☐ Ostomy care - Freq _____
☐ Wound care - Freq _____
☐ Catheterization - Freq _____
Medication Regime
☐ Complex Meds >every 8hrs per day or includes (IV, SubQ, or Nebulizations)

Neurological
☐ Paralysis; type _____
☐ Spasticity
Cognitive Mild ☐ Mod ☐ Severe ☐
☐ Intellectual or Dev. Disability
☐ Other
Caregiver limitations
(Cognitive/social/physical)
☐ Specify_____
_____

Activities of Daily Living (with or without cueing):

Bathing: (Check one)	I ☐ M ☐ D ☐	Social	I ☐ M ☐ D ☐
Grooming: (Check one)	I ☐ M ☐ D ☐	Emotional	I ☐ M ☐ D ☐
Dressing: (Check one)	I ☐ M ☐ D ☐	Attention	I ☐ M ☐ D ☐
Eating: (Check one)	I ☐ M ☐ D ☐	Safety/Judgment	I ☐ M ☐ D ☐
Mobility-Ambulation	I ☐ M ☐ D ☐	Incontinence > 3 yo	Y ☐ N ☐

I= independent (able to do it on their own w/very minimal assistance)
M=moderate dependence (needs minimal to moderate assistance)
D=dependent (cannot perform on their own without maximal assistance)

Other pertinent clinical information:

PROVIDER NAME (MD or NP): Please Print	**Signature/ Date:**
Phone Number:	