COÖS COUNTY NURSING HOSPITAL
P.O. BOX 10
WEST STEWARTSTOWN, NH 03597
Phone: (603) 246-3321 FAX: (603) 246-8117

PHYSICIAN CARE REFERRAL FORM

PATIENT'S NAME, HOME ADDRESS, TELEPHONE PCP: DOB: Sex: Date of Admission:	
Medicare Number:	Medicaid Number:
DIAGNOSIS/ACTIVE PROBLEMS AT THIS TIME: Primary: Secondary: Other Problems:	
ABBREVIATED HISTORY, PHYSICAL, AND FINDINGS:	
ALLERGIES:	

Infection/Immunization Status:

Current or History of MDRO i.e.: ❑ C-Diff ❑ MRSA ❑ OTHER:

DATE OF: PNEUMOVAC:	LAST FLU SHOT:	TETANUS:
SHINGLES VACCINE:	LAST TST:	RESULT:

PHYSICIAN'S PLAN OF CARE:

❑ **Scripts for Controlled Substances Included**
❑ **Pharmacy:** **Rite Aid or Omnicare** ❑ **Bridge Script for 72 hours**

I certify that ICF level of care is medically necessary for the proper care of the patient.

Physician Signature _____ Date _____

Physician Name (Print) _____ Address _____

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❑ **INITIAL REFERRAL** ❑ **RE-ADMISSION REFERRAL**

PATIENT'S NAME:
DOB: Sex:

FUNCTIONAL STATUS:

	Independent	Assistance	Unable
Bathing			
Toileting			
Eating			
Dressing			
Mobility			
Transfers			
Walking			
Wheelchair			
Stairs			

SPECIAL CARE:

	Type
Tube Feeding	
PT/OT/ST	
Diet	
Other	

WOUND CARE:
Type of Wound: _____
_____
Size & Dressing: _____
_____

MENTAL STATUS:

	Never	Sometimes	Always
Oriented			
Depressed			
Wanders			
Aggressive			

BLADDER FUNCTION:
❑ Continent
❑ Incontinent
❑ Foley
Size: Date:

BOWEL FUNCTION:
❑ Continent
❑ Incontinent
❑ Colostomy
Last BM

IMPAIRMENTS:

	None	Partial	Total
Vision			
Speech			
Hearing			
Dentition			

ADDITIONAL CLINICAL INFORMATION:
O2 Sat _____ Current Weight_____
Patient has: Current Height _____
❑ G Tube ❑ Frequent Falls
❑ J Tube ❑ History of Falls
❑ Tracheostomy ❑ Other _____

ASSISTIVE DIVICES: (please circle if applicable)
❑ Glasses ❑ Prosthesis ❑ Crutches ❑ Hearing Aids R L Both
❑ Walker ❑ Wheelchair ❑ Cane ❑ Dentures U L Both

DISABILITIES:	None	Partial	Total	Location
Paralysis				
Contracture				
Amputation				
Joint Motion				
Fracture				

COPY/FAX TO CCNH:
❑ History & Physical
❑ Labs/X-Rays
❑ Discharge Summary
❑ Medication List
❑ Therapy Notes
❑ F/U Medical Appointments

NURSING PLAN OF CARE:

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Signature:	Date: