



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

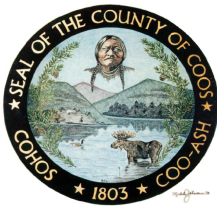
PHYSICIAN CARE REFERRAL FORM

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:		
<u>Infection/Immunization Status:</u>		
Current or History of MDRO i.e.: <input type="checkbox"/> C-Diff <input type="checkbox"/> MRSA <input type="checkbox"/> OTHER:		
DATE OF: PNEUMOVAC:	LAST FLU SHOT:	TETANUS:
SHINGLES VACCINE:	LAST TST:	RESULT:
PHYSICIAN'S PLAN OF CARE:		
<input type="checkbox"/> Scripts for Controlled Substances Included <input type="checkbox"/> Pharmacy: Rite Aid or Omnicare <input type="checkbox"/> 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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NURSING CARE REFERRAL FORM

☐ INITIAL REFERRAL

☐ RE-ADMISSION REFERRAL

PATIENT'S NAME:						
DOB:				Sex:		
FUNCTIONAL STATUS:				SPECIAL CARE:	Type	
	Independent	Assistance	Unable	Tube Feeding		
Bathing				PT/OT/ST		
Toileting				Diet		
Eating				Other		
Dressing				WOUND CARE:		
Mobility				Type of Wound: _____		
Transfers				Size & Dressing: _____		
Walking						
Wheelchair						
Stairs						
MENTAL STATUS:				BLADDER FUNCTION:	BOWEL FUNCTION:	
	Never	Sometimes	Always	<input type="checkbox"/> Continent	<input type="checkbox"/> Continent	
Oriented				<input type="checkbox"/> Incontinent	<input type="checkbox"/> Incontinent	
Depressed				<input type="checkbox"/> Foley	<input type="checkbox"/> Colostomy	
Wanders				Size: _____ Date: _____	Last BM _____	
Aggressive				ADDITIONAL CLINICAL INFORMATION:		
IMPAIRMENTS:				O2 Sat _____	Current Weight _____	
	None	Partial	Total	Patient has:	Current Height _____	
Vision				<input type="checkbox"/> G Tube	<input type="checkbox"/> Frequent Falls	
Speech				<input type="checkbox"/> J Tube	<input type="checkbox"/> History of Falls	
Hearing				<input type="checkbox"/> Tracheostomy	<input type="checkbox"/> Other _____	
Dentition						
ASSISTIVE DEVICES:						
(please circle if applicable)						
<input type="checkbox"/> Glasses	<input type="checkbox"/> Prosthesis	<input type="checkbox"/> Crutches	<input type="checkbox"/> Hearing Aids R L Both			
<input type="checkbox"/> Walker	<input type="checkbox"/> Wheelchair	<input type="checkbox"/> Cane	<input type="checkbox"/> Dentures U L Both			
DISABILITIES:	None	Partial	Total	Location	COPY/FAX TO CCNH:	
Paralysis					<input type="checkbox"/> History & Physical	
Contracture					<input type="checkbox"/> Labs/X-Rays	
Amputation					<input type="checkbox"/> Discharge Summary	
Joint Motion					<input type="checkbox"/> Medication List	
Fracture					<input type="checkbox"/> Therapy Notes	
					<input type="checkbox"/> F/U Medical Appointments	
NURSING PLAN OF CARE:						

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Signature:

Date: