INTER-AGENCY PATIENT REFERRAL REPORT

W-10 (Rev. 7/93)

STATE OF CONNECTICUT DEPARTMENT OF SOCIAL SERVICES - Health Services

IDENTIFYING DATA

PATIENT'S NAME (Last, First, Middle)	SEX	BIRTH DATE	ADMISSION DATE	DISCHARGE DATE

PATIENT'S HOME ADDRESS (No. and Street, Town or City, State, Zip Code)	HOME PHONE NO.	MARITAL STATUS	RELIGION

RESPONSIBLE PERSON OR AGENCY (Name and Address)	TELEPHONE NO.

REFERRED BY (Name and Address of Facility or Agency)	CONTACT PERSON OR UNIT	TELEPHONE NO.

REFERRED TO (Name and Address of Facility or Agency)	CONTACT PERSON OR UNIT	TELEPHONE NO.

FOLLOW-UP BY (Name and Address of Physician or Clinic)	TELEPHONE NO.	DATE OF NEXT APPOINTMENT
1.		
2.		

MEDICAL RECORD NO.	MEDICARE NO.	SOCIAL SECURITY NO.	DEPT. OF SOCIAL SERVICES NO.	OTHER

PATIENT CARE INFORMATION AND ORDERS

PERTINENT HISTORY (Include dates of diagnosis and problems) AND PLAN OF CARE (Include treatment, diet, activity permitted)

DIAGNOSIS:

CODE STATUS: _____

MENTAL STATUS: _____

SKIN INTEGRITY: _____

ACTIVITY LEVEL: _____

DIET:

REASON FOR TRANSFER:

WERE THE FOLLOWING SENT WITH PATENT?

LIVING WILL ..... YES / NO

ADVANCED DIRECTIVES ..... YES / NO

EYEGLASSES ..... YES / NO

HEARING AID(S) ..... YES / NO

DENTURES

UPPER ..... YES / NO

LOWER ..... YES / NO

RESPONSIBLE PARTY AWARE ... YES / NO

T_____P_____R_____BP_____

LAST BM_____FOLEY_____DATE_____NURSES SIGNATURE_____

MEDICATIONS (Drug, Strength, Mode)	FREQUENCY	LAST GIVEN	MEDICATIONS (Drug, Strength, Mode)	FREQUENCY	LAST GIVEN
1.			2.		
3.			4.		
5.			6.		
7.			8.		

ALLERGIES	DIAGNOSIS GIVEN	EXPLAINED TO	PROGNOSIS	EXPLAINED TO
		☐ Patient ☐ Family		☐ Patient ☐ Family

THERAPEUTIC GOALS

PATIENT SERV. START DATE	SERVICES REQUESTED							(specify)
	☐ Nursing	☐ Occ. therapy	☐ Speech therapy	☐ Physical therapy	☐ H. H. aide	☐ Social work	☐ Other	

IS TREATMENT FOR CONDITION FOR WHICH PATIENT WAS HOSPITALIZED (If NO explain) ☐ Yes ☐ No

PATIENT ESSENTIALLY HOMEBOUND ☐ Yes ☐ No

I HEREBY CERTIFY THAT THE ABOVE SERVICES SHOULD BE PROVIDED BY ☐ Acute Hosp. ☐ Chronic Hosp. ☐ NF ☐ Home Health Agy. ☐ Rehab. Center

SIGNED (Physician)

DATE SIGNED