P3 Health Partners Nevada

Built by Doctors. Loved by Patients.

P3@Home

Taking Care of Patients Where They Need it Most

P3 @ Home Referral

(725) 231-8000

Date:__________________ Patient Name: ____________________________________

Patient Phone No.:________________________________ DOB: _____________________

Patient's Ins. Payer: ____________________________________

Referral Source:

☐ Care Mgmt. ☐ PCP ☐ Patient ☐ Other: ________________

Note: Request records on behalf of the patient (i.e. Problem List, Last Clinic Visit Note, Medication List, DNR)

Name of Referral Source (other than Patient)**:**______________________________________

Phone No. for Referral Source: ____

Reason for Referral:____

Home Visit Location: ____

Number of Hospitalizations (within last 12 months):_______________

Chronic Conditions: (select all that apply)

☐ CHF ☐ COPD ☐ Diabetes Mellitus

☐ HTN ☐ Cancer ☐ Atrial Fibrillation

☐ Chronic Kidney Disease (CKD) ☐ Renal Failure ☐ Amputation

☐ Dementia ☐ Chronic/Recurring Infections ☐ Psychiatric Conditions

Goal(s) of Home Visit: ____

____

Anticipated Length of Time Patient Will Need Home Visits:_______________

Does the Patient Currently Have? _____ Home Health _____ PT _____ OT

Is the Patient able to Make Medical Decisions? _____ Yes _____ No

If No, is there a POA in place? _____ Yes_____ No

Submit completed forms to P3 Home Care via email homecare@p3hp.org