Peritech Home Healthcare
Maternal / Child Home Healthcare

INTAKE / REFERRAL FORM
Please Fax to (814)375-1180
Local Office Number (814)375-2703 or 1-800-634-5670

Patient name: _____ DOB: _____ Sex: M or F Ethnicity: _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone #: _____ Cell #: _____ Work #: _____
Patient is: ___at home at hospital ____ Primary Language: _____ SS#: _____
Emergency Contact: _____ Relationship: _____ Phone#: _____
Primary Insurance: _____ Policy #: _____ Group #: _____
Eligibility/Benefits #: _____ PreCert #: _____ Group Name:_____
Policy Holder: _____ DOB: _____ SS#: _____
Referring Physician: _____ Consulting MFM: _____ Phone #: _____
Hospital: _____ Phone #: _____ Fax#: _____
Contact Person at Referral Source: _____ Phone #: _____
Potential Hospital Discharge Date: _____ Hospital Discharge Date: _____ SOC: _____
Requested Visit Frequency: _____
Medication Allergies _____ Current medications _____
Staff Signature: _____ Date: _____

SERVICES REQUESTED

Preterm Labor
___ Home Uterine Activity Monitor
___ 17 Alpha-Hydroxprogesterone Carpote Therapy
EDC _____ G___ P___
Other _____

Nausea and Vomiting in Pregnancy
___Continuous SQ Metoclopramide Therapy (Reglan)
___ Continuous SQ Ondansetron Therapy (Zofran)
N/V onset _____ Wt Loss _____
Ketones _____ #Emesis/24 hours _____
Tolerating PO ___yes ___no
EDC _____ G___ P___

Hypertension
___Gestational Hypertension Program
___Preeclampsia Program G___ P ___
Baseline B/P _____ Current B/P _____
Proteinuria _____ Edema _____ EDC _____
Other s/s _____

Coagulation Disorders
___Continuous SQ Anticoagulation Therapy
___Current Anticoagulation Dose G___ P___
APTT_____ PLT _____ Other _____ EDC _____

NAS
___DOD NAS Scores in Hospital_____
Treated in hospital for NAS _____
Frequency of visits _____ BW _____ CYS involved_____

Postpartum
___Baby only ___Mom only ___Mom/Baby
Delivery Date_____ Vaginal ___ CSection___
Frequency of visits _____ DOD _____
Preterm Delivery at _____ BW _____

Jaundice
BW _____ Current Weight ____ Blood Type ___
Bilirubins/Dates _____
Coombs __positive __negative Feeding_____
Biliblanket __yes __no Bili draw SOC _____

Pediatrics
___SNV follow up ____Private Duty
Skills _____
Frequency of visits _____

Diabetes
___Gestational Diabetes Program
___Daily Insulin Injections
___Cont SQ Insulin Infusion
___Gestational ___Pre gestational Type I or Type II
___ Diet Controlled ___Insulin Needed
Current Diet _____ A1C _____
Recent BGs _____
1 HR Screen _____ Date _____
3 HR GTT fasting _____ 1 HR _____
2 HR _____ 3 HR Date _____
EDC _____ G ___ P___

NICU
_____DOD Diagnosis_____ M.D. Appt_____
Breastfeeding_____ Bottle Feeding_____ BW _____
Discharge Weight_____

Antepartum
Reason for Visits_____ EDC_____ EGA_____
G__P__ Other_____