Avanti HOME HEALTH CARE
37650 Professional Center Drive., Suite 145-A
Livonia, MI 48154
Phone: 734-779-9900 Fax: 734-779-9100

ORDER TO START CARE

(Continuing Plan of Care)

REFERRAL DATE: _____ / _____ / _____

PATIENT NAME: _____

ID #: _____ PHONE: ( ) _____

ADDRESS OF CARE: _____

_____

Patient's Address: (if Different from above) _____

_____

DATE OF BIRTH: _____ /_____/ _____

SEX: [ ] Male [ ] Female

MARITAL STATUS: _____

RESPONSIBLE PARTY: _____

RELATIONSHIP:_____ PHONE: ( ) _____

DIAGNOSIS:

_____

_____

_____

_____

PHYSICIAN NAME: _____

ADDRESS: _____

_____

PHONE: ( ) _____ FAX: ( ) _____

NPI:_____

INSURANCE INFORMATION

Medicare No.: _____

Medicaid No.: _____

BCBS No.: _____

Name of Subscriber: _____

Other Insurance: _____

Policy Number and Subscriber: _____

Brief Medical History:

_____

_____

_____

Dear Doctor _____:

This is a request order to start care for patient. The disciplines marked below will be evaluating the patient's status and condition.

[ ] Skilled Nursing
[ ] Physical Therapy
[ ] Occupational Therapy
[ ] Social Worker (MSW)
[ ] Speech Therapist
[ ] Home Health Aide
[ ] Other: (Specify) _____

By signing and dating this form, you agree with the START OF CARE. We will be sending you a verbal order after admission. Please mail / fax this order to the written address / fax above within 24-48 hours.

_____ _____

Physician's Signature Date