Oasis Home Health Care Referral Form

Name: _____ DOB: _____
Gender: ☐ Male ☐ Female ☐ Non-Binary ☐ Other ☐ Prefer not to say
Race/Ethnicity: _____
Cultural/Religious Practices: _____
Marital Status: _____
Is resident their own legal decision-maker? ☐ Yes ☐ No If no, specify: ☐ Guardian ☐ POA ☐ Other
Name & Relationship of Legal Representative: _____ Number: _____
Advance Directive: ☐ Yes ☐ No
Referral Source Name: _____ Referral Contact: _____
Is Resident on a Medical Waiver: ☐ Yes ☐ No If yes, specify type: _____
Insurance: _____
Case Manager: _____ Number: _____
Current Living Situation: ☐ Home ☐ Hospital ☐ Rehab ☐ Nursing Home ☐ Other
Primary Diagnoses: _____
Special Treatments: _____
Chronic Conditions: _____
Allergies: _____
Special Diet: _____
Cognitive status: ☐ Alert ☐ Mild cognitive impairment ☐ Disoriented Memory impairment
Medical Equipment Used: ☐ Oxygen ☐ CPAP/BIPAP ☐ Feeding Tube ☐ Catheter ☐ Hoyer lift
Currently Receiving Behavioral/Mental Health Services? ☐ Yes ☐ No
Aggression/Assaultive Behaviors: ☐ Yes ☐ No | If yes, frequency ☐ Rare/occasional ☐ Intermitted ☐ Constant
History Suicide attempts or behaviors: ☐ Yes ☐ No | If yes, when was last attempt:
_____
History Self-harm or risk behaviors: ☐ Yes ☐ No
Fall Risk: ☐ Low ☐ Moderate ☐ High
Indicate level of assistance required:
Bathing: ☐ Independent ☐ Assist ☐ Total Care
Dressing: ☐ Independent ☐ Assist ☐ Total Care
Toileting: ☐ Independent ☐ Assist ☐ Incontinent
Mobility: ☐ Walks ☐ Uses Walker ☐ Wheelchair ☐ Bedbound
Transfers: ☐ Independent ☐ One-Person ☐ Two-Person Assist
Hearing/ Aids: ☐ Yes ☐ No
Vision: ☐ No glasses ☐ Glasses ☐ Legally blind ☐ Blind
Dental Status: ☐ Own teeth ☐ Full dentures ☐ Partial dentures
Eating: ☐ Independent ☐ Assist Requires ☐ Feeding
Incontinence: ☐ None ☐ Bladder ☐ Bowel If Yes, Managed with: _____
Speech: ☐ Verbal ☐ Non-verbal
Smoker: ☐ Yes ☐ No If Yes, what: _____
Substance Use: ☐ Yes ☐ No If Yes, what: _____
History of fire setting or risky behaviors: ☐ Yes ☐ No
Registered sex offender: ☐ Yes ☐ No

Please complete this form to the best of your knowledge. Thorough information helps ensure appropriate care and service planning for the individual. If available, please attach: current medication list and any relevant clinical notes or assessments.
Submit completed forms and attachments via: Fax: 612-887-7430 Email: admin@oasishomehealthmn.com