St. Claire's Home Health
Providing Continuum of Care

27171 Calaroga Ave.
Suite 12
Hayward, CA 94545

Please Fax: (510) 887-4401

Face Sheet, History & Physical

Referral Date: _____/_____/________

Have questions?
Call us (510) 887-4400

FAX REFERRAL

From: ____________________________ Phone:___________________ Fax: ____________________

Referring Physician: ____ Phone: ____________________

PATIENT INFORMATION

Name: _____________________________________ Home Phone: _____________________________

Address: ___________________________________ City: ______________________ CA ___________

SS # _______-______-________
DOB: _______/______/________
Discharge Date : _______/______/________

Caregiver in Home Yes No

ER Contact name : __________________________ ER Contact Tel: _____________________________

PAYOR

Medicare No. ______________________________

DIAGNOSIS

- ☐ Diabetes
- ☐ CVA
- Hypertension
- Wound Care; please specify:

____

- ☐ CHF
- ☐ COPD
- ☐ Gait Disturbance
- ☐ Other; please specify:

____

SURGICAL PROCEDURE : __________________________________ Date: _______/______/________
ADDITIONAL NOTES: ____

____

SERVICES REQUESTED

- ☐ Skilled Nursing
- ☐ Physical Therapy
- ☐ Occupational Therapy
- ☐ Speech Therapy
- ☐ Medical Social Worker
- ☐ Home Health Aide

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