Home health questionnaire

Patient's name: _____ **Phone:** _____

Healthcare provider's name: _____ **Date:** _____

Please complete this assessment to help your healthcare provider determine if you qualify for home health.

1.	Do you have frequent hospital stays or go to the emergency room often?	☐ Yes	☐ No
2.	Do you visit your healthcare provider frequently?	☐ Yes	☐ No
3.	Have you recently been discharged from the hospital?	☐ Yes	☐ No
4.	Have you recently received a terminal diagnosis?	☐ Yes	☐ No
5.	Do you have health issues such as diabetes, lung or heart disease or stroke?	☐ Yes	☐ No
6.	Do you have regular swelling of your feet?	☐ Yes	☐ No
7.	Do you have trouble leaving home or walking?	☐ Yes	☐ No
8.	Do you have shortness of breath with little activity?	☐ Yes	☐ No
9.	Do you experience trouble with bathing or getting around?	☐ Yes	☐ No
10.	Have you had changes to your medication recently?	☐ Yes	☐ No
11.	Do you take multiple medications daily?	☐ Yes	☐ No
12.	Are you confused as to how and when to take your medication?	☐ Yes	☐ No

If you answer yes to any **ONE** of these questions, you might benefit from home health.

Call **833-453-1108** and we will be happy to speak with you about our home health services.

CenterWell™ Home Health