

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.



Home Health services are available for all eligible patients with a healthcare provider referral. CenterWell does not discriminate on the basis of race, color, national origin, age, disability or sex. ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-320-2188 (TTY: 711). 注意: 如果您使用繁體中文, 您可以免費獲得語言援助服務。請致電 1-877-320-2188 (TTY: 711). 1900847-V