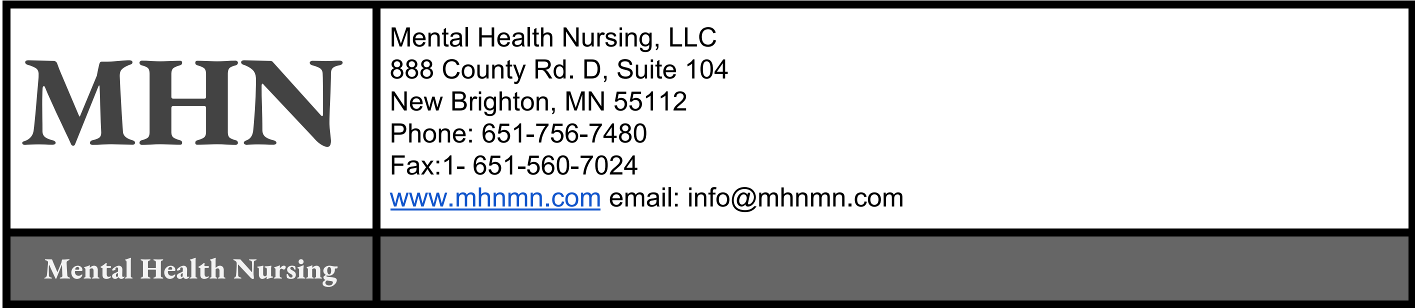

Mental Health Nursing, LLC
888 County Rd. D, Suite 104
New Brighton, MN 55112
Phone: 651-756-7480
Fax:1- 651-560-7024
www.mhnmn.com email: info@mhnmn.com

Referral for MHN Home Health Services

Date: ___________________ ***indicates areas that must be completed**

CLIENT DATA

*Client's full name: ____Phone: ______________________

Referred for (circle one) | 1-2 X week | EOW | q 3 weeks | q4 weeks | nurse visits.

Please prioritize this client's need for services: (1 = very serious/urgent ---------> 5= can wait, has a later start date or hospitalized) | 1 | 2 | 3 | 4 | 5 |

*Address: ____

City: _______________________________ ZIP: _____________ County: ____________________________

alternate phone (home, cell, neighbor): _____________________

*Emergency Contact phone: _____________________________________relationship: _________________

*PMI/MA: ____ *DOB: ______________________________

Other insurance info: ____

*SSN: ____

*Mental health diagnoses: (ICD 10 codes) ____

Medical diagnoses: ____

*Does this client have a guardian (circle one) ? | YES | NO |

Guardian name/phone: ____

*Referral Completed by- Name: ____

*Phone: ______________________________________ email: _____________________________________

PSYCHIATRIST INFO

*Referring physician/psychiatrist ***(provider must be M.D.-- in compliance with Federal CMS regulations)***

*Full Name:____

*Clinic: ____

*Phone: ______________________ *Fax: ______________________ email: ____________________

Psychiatric provider full name (ie: for NP or CNS): ____

*Last appointment with provider: ____________________________ next appt: ___________________

Primary care provider: ____

Clinic: ____

Phone: ____ fax: _______________________________

Specialists, if applicable:

____

____

OTHER SERVICES

*Behavioral health case manager name:____

Agency: ____

*Phone: ________________________*Fax: ____________________ email: ___________________

*CADI/EW Case manager name: ____

Agency: ____

*Phone: ______________________*Fax: ______________________ email: ___________________

PLEASE DESCRIBE CLIENT'S NEED FOR SERVICES

*** MARK ALL THAT APPLY:** ☐ Non-compliance with medication ☐ Confusion with medication

☐ History of overdose ☐ Poor coping mechanisms ☐ Cognitive difficulties ☐Substance abuse

☐Chronic medical conditions ☐ Poor follow-through with refills and with scheduling/keeping appointments ☐ Recent suicide attempt (describe)________________________________

Other: ____

Is client currently under commitment? | YES | NO | If so, expiration date: _________________

Please describe any safety or household concerns the nurse may encounter (ie: hx violent/criminal activity, bed bugs, large pets, etc.):

____

____

____

Date/reason for last hospitalization: ____

If currently hospitalized, estimated discharge date? _______________________________

*Is client aware of and has client agreed to receive home health services from MHN? | YES | NO |

*Does client have a gender preference for nursing? | YES | NO | Male Female

Please explain: ____

*Does client need an interpreter? | YES | NO | For what language? ____________________

preferred agency? ___________________________________

Cultural or spiritual considerations for the nurse?

____

____

<u>*Complete medication list</u>

Name	dose	frequency	route

Attach or send a separate document if needed

Injectable (IM) medication? | YES | NO | if yes, next due date? ______________________

Does client have a current medication supply? | YES | NO | When do they run out?________

OTHER

Please indicate the following:

Does client have an MA Spend down? | YES | NO |

Does client have a rep payee? | YES | NO |

If yes to either of these MHN may contact you for further information.

Please return completed document to MHN by:

fax - (must include 1)1- 651-560-7024

Or email info@mhnmn.com

MHN OFFICE USE ONLY:

Date referral received: ______________________________

Date of physician ordered SOC or ROC (if provided): _________________________________

Tracking notes for this referral including missing information, estimated start date, eligibility, etc.: