Guide to Home Care Services for Health Care Professionals

2013

Home Care Program

GUIDE TO HOME CARE SERVICES

FOR HEALTH CARE PROFESSIONALS (2013)

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A GUIDE TO HOME CARE SERVICES

FOR HEALTH CARE PROFESSIONALS (2013)

THE MANITOBA HOME CARE PROGRAM

The Home Care program was established in 1974 to help people who are living at home remain independent for as long as possible, thereby avoiding or delaying the need for individuals to go into long term care facilities. The mandate of the Program is to provide effective, reliable and responsive community health care services to support independent living, develop appropriate care options with clients and/or caregivers, and facilitate admission into long-term care facilities when living in the community is no longer possible. Home Care also supports caregivers by providing decision-making assistance, and information and/or referrals to other community resources.

In Winnipeg, the Winnipeg Regional Health Authority (WRHA) manages Home Care services. The WRHA currently has Home Care staff located at multiple sites including hospitals, community area offices and specialty programs. A list of phone numbers for the Provincial Health Contact Centre (PHCC) and community sites is attached.

Eligibility

To be eligible for Home Care, an individual must be a Manitoba resident, registered with Manitoba Health, require health services or assistance with activities of daily living, require services to remain safely in their home, and require more assistance than available from existing supports and community resources. Specific services may also have additional eligibility criteria.

Home Care Services

The following are the services that may be provided by Home Care:

- **Personal Care Assistance** – for individuals who are unable to perform independently and do not have a caregiver who may assist:
  - Personal hygiene, dressing, eating, toileting and assistance with ambulating and transferring.

- **Health Care Services** – each service has unique eligibility criteria:
  - Nursing services (teaching, health promotion, wound care, medication administration) usually by order of a Physician/Nurse Practitioner.

- Dietitian assessment and intervention for clients who may be home-bound and/or not appropriate for clinic services.
- Diabetic assessment and intervention for clients who may be home-bound and/or not appropriate for clinic services.

- **Caregiver Support** – for individuals assessed as requiring 24 hour support/supervision due to cognitive and/or functional needs:
  - Direct service staff may be scheduled to provide short periods of in-home respite to allow caregivers to attend to work or school activities, and also for general relief.
  - Facility Based Respite Care – respite care may be arranged to provide longer periods of relief. A client may be admitted to a Personal Care Home or hospital for a period of time. There is a fee for this service.

- **Home Support** – for individuals assessed as being unable to perform independently and without caregiver or other community support options that may provide this assistance:
  - Meals.
  - Household maintenance and laundry.

- **Rehabilitation Services** – for individuals without other community support options that may provide this assistance:
  - Occupational Therapy assessment and intervention.
  - Physiotherapy assessment and intervention.
  - Speech & Language Pathologist assessment and intervention (for clients of the centralized Community Stroke Care Service).
  - Rehabilitation Assistants may be involved in the plan of care (for clients of the centralized Community Stroke Care Service).

- **Supplies & Equipment**
  - Specific types of supplies and equipment may be provided through Home Care (subject to eligibility criteria and limits).

- **Adult Day Programs**
  - These day programs provide group recreational activities outside of the home for individuals who are unable to access community activities. There is a fee for this service.

- **Alternative Living Arrangements**
  - Support with respect to decisions about alternative housing options in the community.
  - When community living is no longer possible, Case Coordinators can complete applications for long-term care options such as Supportive Housing, Companion Care and Personal Care Home placements.

- **Other Resources in the Community**
  - Case Coordinators can provide information about other possible supports that may exist within the community (e.g. meal delivery programs, grocery delivery, senior's agencies, geriatric assessments, support groups, etc.).

CLIENT SERVICE PATHWAY

The client service pathway is the pathway that a client follows through the Home Care program.

Process for Referrals from the Community
(Please refer to Important Community Phone Numbers attached)

Individuals may self-refer, or anyone may refer an individual to the Manitoba Home Care Program for assessment of eligibility for Home Care Services.

Referrals to the Home Care Program may come from several sources in the community, such as clients, caregivers, concerned individuals, Physicians, Nurse Practitioners, Nurses, Outpatient Clinics, Allied Health Care Professionals, and partners within the Winnipeg Integrated Services Initiative (WIS) (i.e. programs that fall under WRHA and Manitoba Family Services and Consumer Affairs).

- **Clients, Caregivers and/or Concerned Individuals:** may call either the Central Intake Unit or the Nursing Intake Unit (if the need is only for nursing service). An intake worker will screen the referral and direct it to the appropriate community Home Care site.

- **Physicians, Nurse Practitioners and Outpatient Clinics:**
  - Central Intake Unit – for general assessment of eligibility for Home Care services, refer to Central Intake by phone, or by fax using the referral form in the Appendices, or by clicking here: *http://www.wrha.mb.ca/professionals/familyphysicians/referral-homecare.php*
  - Nursing Intake Unit – if only nursing services are requested, refer directly to Nursing Unit Intake by phone, or by fax using the referral form in the Appendices, or by clicking here: *http://www.wrha.mb.ca/professionals/familyphysicians/referral-homecare.php*
  - Respiratory – refer directly to the Respiratory Program by calling the Respiratory Program to request a referral form.
  - Palliative – refer directly to the Palliative Care Sub-Program using the referral form in the Appendices, or by clicking here: *http://www.wrha.mb.ca/prog/palliative/files/PalliativeCare_RefForm.pdf*

- **Partners of the Winnipeg Integrated Services Initiative (WIS):** includes referrals from programs that fall under the WRHA and Manitoba Family Services and Consumer Affairs Department. These referrals bypass Central Intake and go directly to the Home Care site or speciality program involved. Be sure to complete the WIS referral form and the Safety Assessment Form Tool (available in each WIS site, or through Central Intake).

Once received, referrals are assigned to a Case Coordinator who is responsible for contacting the client/caregiver to complete an assessment (exception: most nursing-only referrals are coordinated by the primary visiting nurse).

Assessment

The Case Coordinator, in collaboration with the client/caregiver(s) and other health care partners, completes a multidimensional assessment to:

- Identify the needs of a client related to their ability to live independently in the community setting.
- Identify current resources/supports in place.
- Identify risk factors affecting client and/or caregiver safety in the home.
- Assess eligibility for Home Care.

A Case Coordinator is:

- The primary contact for the client regarding their Home Care Services.
- Assigned to a specific geographic or program area, and to specific clients.
- A professional with a background in one or more of the following areas: Nursing, Social Work, Occupational Therapy, Physiotherapy, Respiratory Therapy, Speech Language Pathology or Dietitian Services.

Care Planning & Coordination of Service Implementation

The Case Coordinator, in collaboration with the client/caregiver(s) and other health care partners, is responsible to:

- Identify goals and objectives for care.
- Identify appropriate resources/options to meet identified needs.
- Assist clients/caregivers to access community resources, and other programs and services.
- Coordinate services provided by the Home Care Program.

Reassessment / Evaluation

The Case Coordinator reviews the client functioning and the care plan on a regularly scheduled basis, or as required by changes in the client situation.

CONTACTING HOME CARE

How do you know who the Case Coordinator is?

- Ask the client/caregiver.
- Call the specific office/site.
- Call the Central Intake Unit.
- Review your client file for documentation from the Case Coordinator (e.g. letters, reports).

When might a Health Care Professional be in contact with Home Care?

- To plan for discharge from hospital (via Hospital Home Care Case Coordinator).
- To initiate a new referral requesting an assessment via Central Intake Unit.
- To initiate a new referral for nursing treatments via the Nursing Intake Unit (Physicians and Nurse Practitioners only).
- To discuss a plan of care for the client.

When might Home Care be in contact with a Health Care Professional?

- To discuss/confirm medication/treatment orders.
- To discuss a referral to a resource that requires a Physician or Nurse Practitioner referral (e.g. Diabetes Education Centre, Swallowing).
- To discuss a plan of care for a client.
- To request completion of a Medical Data form required for an application for long Term Care placement options such as Supportive Housing and Personal Care Home.

Physicians and Nurse Practitioners may bill "Tariff 8000" whenever they receive a phone call or fax from allied health personnel requesting information about a specific client (which includes Home Care Case Coordinators and Direct Service Nurses).

HOME CARE DECISION-MAKING

Is guided by a number of factors:

- **Determination of Risk**: Persons receiving Home Care services are assessed regularly and care planning is completed with each person and their caregiver(s). Services are based on this assessment of need, risk and other available supports.

- **Service Limit Policy**
  - The Manitoba Health Service Level Policy states that services required by the client will not generally exceed the equivalent cost of services provided in a care facility. In special circumstances, the care plan (service costs) may temporarily exceed these levels with special approval.

- **Service Protocols**
  - The Winnipeg Regional Health Authority provides protocols that establish how often a task may be performed and how much time can be assigned to each task. The protocols are reviewed and revised regularly.

- **Need for a Backup Plan**
  - The Home Care Program provides services to support a client who wishes to remain living independently in the community. Family and caregivers remain the primary supports to a client, and Home Care is seen as a supplemental support. It is necessary for clients/caregivers to have a backup plan for when Home Care workers are not available.

- **Measurable Outcomes**
  - Home Care uses electronic assessment and care planning tools. These tools generate data containing measurable outcomes that are used to inform program planning decisions.

- **Maximizing Ability to Meet Client Needs**
  - Home Care is currently changing the way service is scheduled in order to maximize on the ability to service the growing population of clients. Home Care is moving towards offering more consistent hours of work for Direct Service Staff, which should result in greater worker retention and satisfaction. During this transition, clients will see changes to their worker schedules.

APPENDICES

1. WRHA Home Care Important Community Phone Numbers (2013)
2. WRHA Home Care Referral Form
3. WRHA Community Health Information Form Completion Guideline
4. WRHA Palliative Care Program Referral Form

Manitoba
Family Services and Housing

Winnipeg Regional Health Authority
Caring for Health

Office régional de la santé de Winnipeg
À l'écoute de notre santé

WRHA HOME CARE
IMPORTANT COMMUNITY PHONE NUMBERS (2013)

PROVINCIAL HEALTH CONTACT CENTRE	Phone	Fax
Central Intake	(204) 788-8330	(204) 940-2227
Nursing Intake	(204) 788-8337	(204) 940-2227
Health Links	(204) 788-8200	
After Hours	(204) 788-8331	(204) 940-2227

HOME CARE COMMUNITY SITES	Phone	Fax
Access River East, 975 Henderson Hwy, R2K 4L7	(204) 938-5200	(204) 938-5119
Access Transcona, 845 Regent Ave. W., R2C 3A9	(204) 938-5555	(204) 938-5511
Assiniboine South, 3401 Roblin Blvd., R3R 0C6	(204) 940-1950	(204) 940-1947
Downtown West, 2nd Fl. – 755 Portage Ave., R3G 0N2	(204) 940-2477	(204) 940-2468
Downtown East, 640 Main St., R3B 0L8	(204) 940-3160	(204) 940-2116
Fort Garry, 2735 Pembina Hwy, R3T 2H5	(204) 940-2015	(204) 261-0888
Point Douglas Team, 4-189 Evanson St., R3G 0N9	(204) 940-6660	(204) 940-2574
River Heights, 102-1001 Corydon Ave., R3M 0B6	(204) 940-2005	(204) 940-2466
Seven Oaks/Inkster, Unit 3 – 1050 Leila Ave., R2P 1W6	(204) 938-5600	(204) 938-5609
St. James/Assiniboia, 2nd Fl. – 2015 Portage Ave., R3J 0K3	(204) 940-2040	(204) 940-2636
St. Boniface/St. Vital, 640 – 5 Donald St., R3L 2T4	(204) 940-2070	(204) 940-2127

HOME CARE SPECIALTY/CENTRALIZED PROGRAMS	Phone	Fax
Children's Home Care	(204) 787-2462	(204) 787-1309
Community IV Program (CIVP)	(204) 938-5407	(204) 938-5780
Community Stroke Care Service	(204) 940-2526	(204) 940-6620
Manitoba Home Nutrition Program	(204) 940-1911	(204) 940-1933
Manitoba Ostomy Program	(204) 938-5757 or (204) 938-5758	(204) 938-5810
Health Coordination Program	(204) 940-2168	(204) 940-6620
Palliative Care Sub-Program	(204) 237-2400	(204) 237-9162
Peritoneal Dialysis Program	(204) 940-2477	(204) 940-2468
PRIME	(204) 833-1700	(204) 940-2125
Respiratory Program	(204) 940-6690	(204) 940-6691
Self and Family Managed Care	(204) 940-2168	(204) 940-6620

Winnipeg Regional Health Authority — Caring for Health
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HOME CARE REFERRAL FORM

Client Health Record #
Client Surname
Given Name
Date of Birth
Gender
MFRN
PHIN
Address (home visits only)

FAX TO: (204) 940-2227

☐ **CENTRAL INTAKE**
☐ **CENTRAL NURSING INTAKE**
☐ **AFTER HOURS SERVICE**
☐ **FACILITY/COMMUNITY AREA:**

ADMISSION DATE: D D M M M Y Y Y Y
DISCHARGE DATE: D D M M M Y Y Y Y
DATE SERVICES TO BEGIN: D D M M M Y Y Y Y

SERVICE (S) REQUESTED:

SERVICE ADDRESS (IF DIFFERENT FROM ABOVE):
PHONE (home): (   )
PHONE (alternate): (   )

CLIENT'S PRIMARY CONTACT NAME:

RELATIONSHIP:
PHONE (home): (   )

LANGUAGES: SPOKEN ☐ ENGLISH ☐ OTHER (SPECIFY):
UNDERSTOOD ☐ ENGLISH ☐ OTHER (SPECIFY):

MEDICAL DIAGNOSES:
ALLERGIES:

TREATMENT/MEDICAL ORDERS: ☐ SEE ATTACHED IF APPLICABLE

MEDICATION ORDERS: NAME/DOSE/ROUTE/FREQUENCY/DURATION ☐ SEE ATTACHED IF APPLICABLE

MEDICATIONS WILL BE IN HOME: ☐ YES ☐ NO IF NO, PROVIDE DETAILS:

LIST OTHER PROGRAMS/SERVICES INVOLVED: (attach list if more room needed)
PHONE: (   )
FAX: (   )

LIVING ARRANGEMENTS:
☐ Alone
☐ With Relatives
☐ With Others

FAMILY SUPPORT AVAILABLE:
☐ YES ☐ NO

SAFETY: (e.g. pets, smoking, etc.)

COMMUNICATION:
Vision Impairment . . . . . . ☐ YES ☐ NO
Hearing Impairment . . . . . ☐ YES ☐ NO
Speech Impairment . . . . . ☐ YES ☐ NO

DAILY LIVING:
Is a client/family member able to:
Prepare Meals . . . . ☐ YES ☐ NO
Do the Shopping . . . . ☐ YES ☐ NO
Do the Housekeeping . . . . . . ☐ YES ☐ NO
Manage Personal Care . . . . . ☐ YES ☐ NO

MOBILITY:
☐ Independent
☐ Independent with Equipment
☐ Needs Assist
☐ Wheelchair Independent
☐ Other:

CONTINENCE:
☐ Completely Continent
☐ Incontinent Urine
☐ Indwelling Catheter
☐ Incontinent Feces
☐ Other:

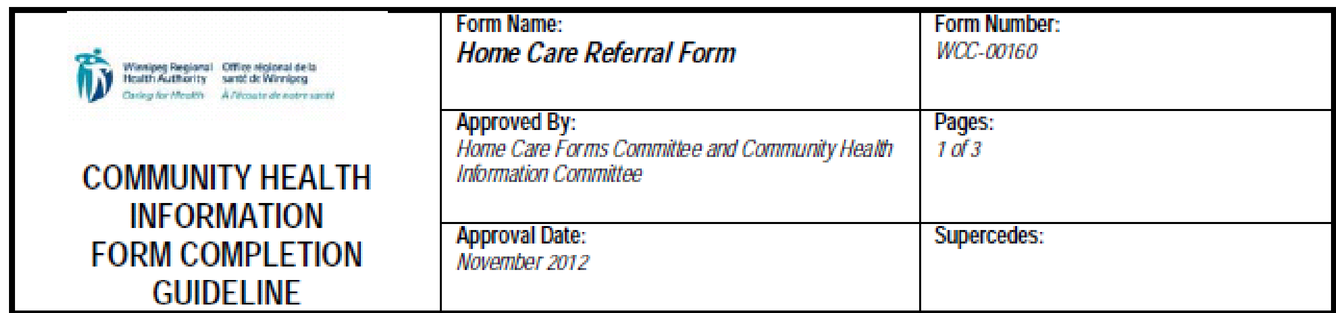
COGNITION AND BEHAVIORAL ISSUES:
Alert and Oriented . . . . ☐ YES ☐ NO
Intact Memory . . . . ☐ YES ☐ NO
Anxiety . . . . ☐ YES ☐ NO
Depressed . . . . ☐ YES ☐ NO
☐ Other:

COMMENTS:

PHYSICIAN'S NAME AND ADDRESS:
PHONE: (   )
FAX: (   )

NAME OF REFERRAL SOURCE (printed):
PHONE: (   )
FAX: (   )

SIGNATURE AND DESIGNATION:
DATE: D D M M M Y Y Y Y



COMMUNITY HEALTH INFORMATION FORM COMPLETION GUIDELINE	Form Name: *Home Care Referral Form*	Form Number: *WCC-00160*
	Approved By: *Home Care Forms Committee and Community Health Information Committee*	Pages: *1 of 3*
	Approval Date: *November 2012*	Supercedes:

INTENT/PURPOSE OF FORM

- To refer clients to the Home Care Program. Please note that the Winnipeg Integrated Services (WIS) referral form will continue to be used by WIS partners.
- Form titled "Nursing Only Form" was previously used for the purpose of referring clients.

DEFINITIONS

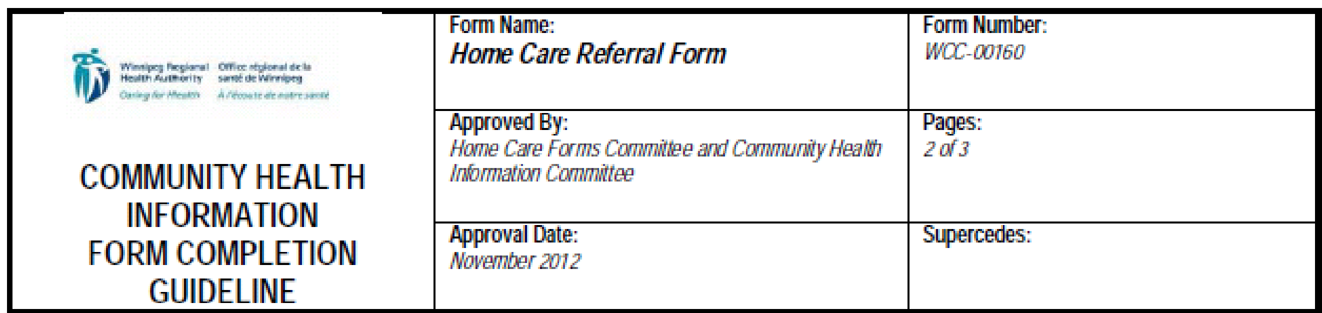
- Central Intake: is part of the Provincial Health Contact Centre and is responsible for determining eligibility for a program assessment.
- Central Nursing Intake: is part of the Provincial Health Contact Centre and is responsible for determining eligibility for Home Care Nursing services.
- After Hours Service: is part of the Provincial Health Contact Centre and is responsible for determining the need for Home Care services during the times outside of regular office hours (i.e. Monday to Friday 4:30 p.m. to 8:30 a.m., and weekends and statutory holidays).

USED BY

- Home Care Hospital Case Coordinators.
- Physicians.
- Emergency Departments outside regular office hours.
- Interim Housing at Misericordia Health Centre for referral of clients being placed in Supportive Housing complexes.

GUIDELINES FOR COMPETION OF FORM

- **Client Demographic Information**: fully complete the upper right hand corner with the identification and contact information of the client, or attach a client label.
- **Fax To**: indicate in the check box the area to which the referral is to be faxed. Indicate the facility or community area, if known.
- **Service(s) Requested**: describe the services that are being requested, and the date the services are to begin, if applicable.
- **Service Address** (if different from above): if client will be staying at an alternate address, indicate their temporary address, including the phone number for the temporary address.



- **Client's Primary Contact Name**: indicate the person to be contacted on client's behalf, their relationship to the client and telephone number.

- **Languages**: indicate the language(s) spoken and understood by client.

- **Medical Diagnoses**: include relevant medical information.

- **Allergies**: indicate allergies.

- **Treatment/Medical Orders**: indicate treatment /medical orders. If not enough space, check "See attached if applicable" and attach signed treatment /medical orders to referral form.

- **Medication Orders:** transcribe medication orders from prescriber or check "See attached if applicable" and attach signed medication list to referral form.

- **Medications will be in Home**: indicate if medications are in the home and, if not, indicate plans to access medications.

- **List Other Programs/Services Involved**: indicate if other agencies are involved, including phone and fax numbers (e.g. Community Disability Services, Employment and Income Assistance). Attach a list if more room is needed.

- **Living Arrangements**: check boxes as applicable.

- **Family Support Available**: check box to indicate if family supports are available or not.

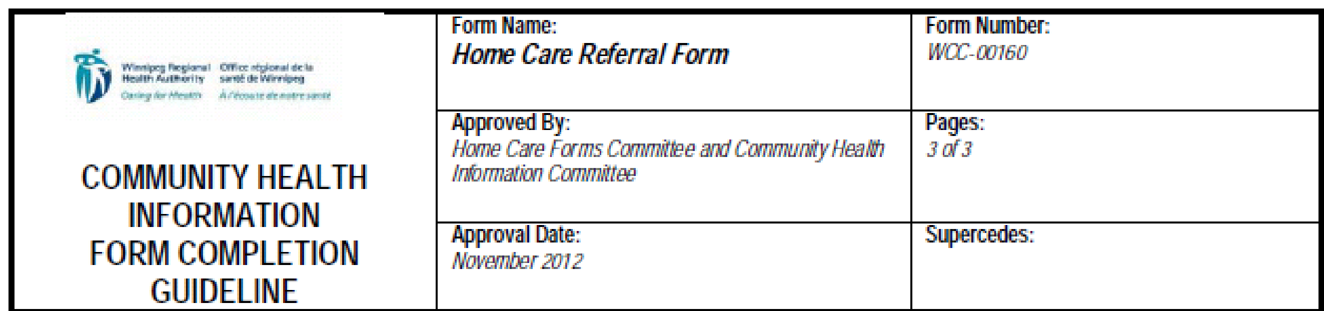
- **Safety**: indicate if there are any possible threats to the safety of Home Care staff.

- **Communication:** check boxes to indicate if vision, hearing, or speech impairment is present or not.

- **Daily Living**: check boxes to indicate whether client or and family is able to perform the identified tasks.

- **Mobility**: check relevant box and, if not identified, indicate what other method of mobility under "Other."

- **Continence**: check box as applicable; identify any other issues under "Other."



COMMUNITY HEALTH INFORMATION FORM COMPLETION GUIDELINE	Form Name: *Home Care Referral Form*	Form Number: *WCC-00160*
	Approved By: *Home Care Forms Committee and Community Health Information Committee*	Pages: *3 of 3*
	Approval Date: *November 2012*	Supercedes:

- **Cognition and Behavioral Issues**: check boxes as applicable; identify any other concerns not listed under "Other."

- **Comments**: add any other relevant comments.

- **Physician's Name and Address**: include the name of the Attending Physician or the Primary Care Physician, whoever is providing the Treatment/Medication Order. Include their address, phone and fax.

- **Name of Referral Source**: include name of individual who is referring client, with phone and fax.

- **Signature & Designation**: include signature and designation of Referral Source, including date.

FILING/ROUTING INSTRUCTIONS

- File in section 1 of the Home Care office paper file.

PRINTING INSTRUCTIONS

- Single form must be printed from INSITE.

AUTHOR:

- Lynne Anderson Case Management Specialist, Deanna Tittlemier Resource Coordinator Specialist.

Palliative Care Program
Application for Registration

Complete all sections of this form and forward to:
(Incomplete forms may delay processing.)

WRHA Palliative Care Program
A8024 - 409 Taché Avenue
Winnipeg, Manitoba, R2H 2A6
Phone: (204) 237-2400
Fax: (204) 237-9162

Addressograph	Date:
	Person Referring Patient:
	Source of Referring Agency:
	Telephone:

CLIENT IDENTIFICATION

Full Name:	Male: ☐	Female: ☐
Address:	Telephone:	
Date of Birth (Day / Month / Year)	MHSC Family Number:	PHIN Number:
Next of Kin Name:	Relationship:	
Address:	Telephone:	
Primary Physician or Nurse Practitioner Name:	Fax Number:	Telephone:
Name of Health Care Provider:	Fax Number:	Telephone:
Name of Health Care Provider:	Fax Number:	Telephone:
Name of Psychosocial Clinician:	Fax Number:	Telephone:

CLINICAL INFORMATION

Primary Diagnosis / Known Metastases & Summary of Progression of Disease:

Date of Diagnosis:

Urgency of Referral: Immediate Attention: ☐ Attention Within 2 Weeks: ☐

Estimated Prognosis: Less than one week ☐ Less than one month ☐ 1 to 3 months ☐ 3 to 6 months ☐ Over 6 months ☐

Treatment History: ChemoTx (date of last Tx). Radiation Therapy (where & when). Further treatment planned? Specify. Recent Investigations (Please attach information).

Current Issues: (Symptom Management / Psychosocial / Spiritual / Functional Decline)

Past Medical History:

Past/Present Alcohol Use: Smoker:

Allergies or Medication Intolerances (Please Describe):

Current Medications: (Specify doses and frequency)

CURRENT FUNCTIONAL STATUS

	Independent	Partial Assist	Complete
Ambulation:	☐	☐	☐
Transfers:	☐	☐	☐
Continence:	☐	☐	☐
Bathing:	☐	☐	☐
Dressing:	☐	☐	☐
Ability to feed self:	☐	☐	☐

Comments:

COGNITION:	No issues identified ☐	Intermittently Confused ☐	Consistently Confused ☐
MOOD:	Anxious ☐	Depressed ☐	Agitated ☐
BEHAVIOUR	Appropriate ☐	Inappropriate (Comment): ☐	

COMMUNICATION

☐ English is spoken and understood ☐ Other Language:

Communication barriers:

SOCIAL INFORMATION

Support System / Network:

If currently hospitalized - has the option of discharge home been explored? Yes ☐ No ☐

Barriers to discharge home are:

Patient and family are aware of referral to Palliative Care Program? Yes ☐ No ☐

Is client / family in agreement with referral to a Palliative Care Consult if needed? Yes ☐ No ☐

The Following Documentation Must Be Completed By A Physician or Nurse Practitioner

Completion of this form does not mean patients will be registered on the WRHA Palliative Care Program. After the information on this form has been reviewed, you will be notified in writing regarding acceptance for registration on the WRHA Palliative Care Program.

Discussion regarding "End of Life" care wishes and expectations is a natural and important component of the process of initiating a application for registering on the Palliative Care. The application usually reflects a transition in focus of care and in hoped-for outcomes. Such discussions are best undertaken by the health care providers with whom a relationship has already been established; this would usually be the referring physician or nurse practitioner.

Registration on the WRHA Palliative Care Program requires that the patient (or family, if the patient is not competent) is not expecting attempted resuscitation in the event of the cessation of cardiac and/or pulmonary function. Patients should not be undergoing or planning a course of treatment with expectations of monitoring for and intervening for complications in a manner other than comfort-focused (this usually refers to chemotherapy).

Acceptance of "Do Not Attempt Resuscitation" (DNAR) by patient (or family if patient not competent)? Yes ☐ No ☐

The following issues have been discussed:

1. Does the patient have a Health Care Directive ("Living Will") or Advance Care Plan? Yes ☐ No ☐
2. If "No", has this been discussed? Yes ☐ No ☐
   Has there been discussion of treatment issues related to end of life care? Yes ☐ No ☐
   (antibiotic use, blood transfusions, fluids, etc)
3. Has the patient been informed of diagnosis and prognosis? Yes ☐ No ☐
   If "No", please explain:
4. Has the family been informed of diagnosis and prognosis? Yes ☐ No ☐
   If "No", please explain:
   Other comments:

Physician / Nurse Practitioner Follow-Up:

1. The Palliative Care Drug Access Form has been completed and is included with application for registration Yes ☐ No ☐
2. Will you accept consultation by a Palliative Care Physician Consultant if indicated? Yes ☐ No ☐
3. Is the Primary Care Provider aware of referral? Yes ☐ No ☐
4. Will you continue to be the Primary Care Provider while the patient is out of the hospital? Yes ☐ No ☐
5. Will you continue to be involved in the patient's care? Yes ☐ No ☐
6. If you will not be the Primary Care Provider, who will? Name: Telephone:

Physician's or Nurse Practitioner's Signature:	Name (Please print):	Date:

FOR OFFICE USE ONLY:

Accepted: ☐ **Pending:** ☐ **Rejected:** ☐ **Date:** ______

Explanation (Pending / Rejected):