

Home health questionnaire

Patient's name: _____ Phone: _____

Doctor's name: _____ Date: _____

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

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

If you or a loved one 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 help at home.



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: 如果簡使用繁體中文, 簡可以免費獲得語言援助服務。請致電 1-877-320-2188 (TTY: 711). 1900847-V