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

CenterWell™ Home Health