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 answer yes to any **ONE** of these questions, you might benefit from home health.
Call **866.CARE.KAH** and we will be happy to speak with you about help at home.

www.kindredathome.com

Kindred at Home is a family of community care, personal home care, home health, palliative and hospice providers.

We accept patients for care regardless of age, race, color, national origin, religion, sex, disability, being a qualified disabled veteran, being a qualified disabled veteran of the Vietnam era, or any other category protected by law, or decisions regarding advance directives. © 2021 Kindred at Home 1900847-S