Better Care for Better Outcomes™

Referral Form

Please complete and fax the following information (or attach demographics / face sheet) and office visit note to: (844) 333-0623.

Patient

Patient Name _____ SSN _____

Date of Birth _____ M | F Address _____

Phone _____ City, State, Zip _____

Alternate Contact Name _____ Last Flu Vaccine Date _____

Alternate Contact's Number _____ Referral Date _____

Primary Care Physician _____ Insurance Information _____
(or attach copy)

Office Contact Name _____ Office Contact Number _____

DIAGNOSIS / MEDICAL CONDITION *(List the diagnosis / medical conditions that are the primary reason the patient requires home health care.)*

_____

SKILLED SERVICES/INTERVENTIONS *(Describe services the nurse or therapist will perform in the home, e.g. assess, teach, wound care, gait training.)*

Skilled Nursing for _____ Physical Therapy for _____

Speech Therapy for _____ Occupational Therapy _____

Social Work _____ Home Health Aide _____

ADDITIONAL ORDERS: _____

Certification for Face-to-Face

I certify that this patient is under my care and that I, or a nurse practitioner or physician's assistant working with me or a physician who cared for the patient in an acute or post-acute facility had a face-to-face encounter related to the primary reason the patient requires home health that meets CMS requirements with this patient on:

Face-to-Face Encounter Date _____ / _____ / _____

Based on the above findings, I certify that this patient is confined to the home and needs intermittent skilled nursing, physical therapy, and/or speech therapy. The patient is under my care and I have initiated the establishment of the plan of care for home health.

Physician's Printed Name:

Physician's Signature _____ **Signature Date** _____

OPTIONAL PHYSICIAN DOCUMENTATION

This section is provided for the physician's convenience and record keeping in the event of a Medicare audit.

CLINICAL FINDINGS *(Signs and symptoms of medical condition exhibited by the patient during the encounter that support the need for all services listed above.)*

_____

_____

HOMEBOUND STATUS *(Describe the clinical and / or physical findings and the functional limitations that result in the patient's normal inability to leave home.)*

_____

_____

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