

Home Health Referral

Referral date: _____

We will see your patient within 48 hours unless a specific start of care date is provided here: _____

Patient name: _____

Address: _____ City: _____ State: _____ ZIP: _____

Phone: _____ DOB: _____ Male Female

Alternate contact: _____ Contact #: _____ Relationship: _____

Payer: Medicare Insurance (insurance contact #): _____
 Medicaid Yes No Other: _____

HIC/ID#: _____ Policy #: _____ Group #: _____

Referring Primary Care Provider: _____ Phone: _____

Referring facility: _____

Primary Care Provider for home health orders: _____ Phone: _____

Diagnoses: _____

Face-To-Face Encounter

Visit within past 90 days: Yes No **Face-To-Face Encounter date:** _____

Please send the completed referral form and attach a copy of the Primary Care Provider's most recent signed and dated encounter with this patient which supports the reason for the ordered Home Health services. Examples may include: Primary Care Provider progress note, history and physical, discharge summary.

Orders

Skilled Nursing for: Medication management and teaching Disease management and teaching
 Observation and assessment of: _____

Wound care (specify below or attach orders): Location: _____ Frequency: _____

Clean w/: _____ Dress w/: _____

Pack w/: _____ Cover w/: _____

Infusion (attach orders) Yes No Other (specify): _____

Physical Therapy for: Evaluation and treatment Other (specify): _____

Occupational Therapy for: Evaluation and treatment Other (specify): _____

Speech Therapy for: Evaluation and treatment Other (specify): _____

Home Health Aide for: Personal care/assist with ADLs

Medical Social Worker for: Community resources Long-term planning Other (specify) _____

Specialty Programs

<input type="checkbox"/> Cardiopulmonary/Keeping Hearts at Home	<input type="checkbox"/> MyNICaS™	<input type="checkbox"/> Safe Strides®
<input type="checkbox"/> Daily Difference with Diabetes	<input type="checkbox"/> Orthopedic	<input type="checkbox"/> Sepsis
<input type="checkbox"/> Low Vision	<input type="checkbox"/> PRIME Wound Care™	<input type="checkbox"/> Zontago®

Print Primary Care Provider's name: _____

Primary Care Provider's signature: _____ **Date:** _____