HOME HEALTH REFERRAL FORM

7450 NW 57th Street●Tamarac, FL 33319
Phone:954-780-3717●Fax: 866-858-8031

Patient Name: _____ Referral Date: _____

Physician-specific SPC date (if applicable): _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Email: _____ DOB: _____

Surgical Procedure (if applicable): _____ Date: _____

Facility Admit Date: _____ Discharged from (facility): _____

Payor: □ Medicare □ Other (please specify): _____

ID# _____ Policy #: _____ Group #: _____

Primary Diagnosis: _____ _____

Other pertinent Home Health Diagnoses: _____ _____

Service: SN _____X per week for _____ weeks HHA _____ X per week for _____ weeks

PT _____X per week for _____ weeks ST _____ X per week for _____ weeks

OT _____X per week for _____ weeks MSW _____ X per week for _____ weeks

Height: _____ Weight: _____ Allergies: _____

History: _____

_____

Orders: _____

_____

The remainder of this form must be completed by the referring physician or the physician's support staff. Documentation of Face-to-Face Encounter for Medicare Patients:

Date of Face-to-Face Encounter: I certify that this patient is under my care and that I, or a nurse practitioner or a physician's assistant working with me, had a Face-to-Face Encounter that meets the physician face-to-face encounter requirements with this patient on (enter date visit occurred) _____

Medical Condition: The primary medical reason, diagnosis, or condition related to the reason for home healthcare for the encounter was:

_____

Medical Necessity: I believe that based on my clinical findings, the patient is homebound and the following home health services are medically necessary:

□ Skilled Nursing □ Physical Therapy □ Occupational Therapy □ Speech Therapy □ Home Health Aide □ MSW □ Other _____

Clinical Findings: Other Conditions/Diagnoses related to the needed home care: _____

_____

_____

Physician Signature: _____ Signature Date: _____

Physician Printed Name: _____