ONLY CARE
HOME HEALTH

PATIENT REFERRAL FORM

CMS may request medical records from Physicians. Please retain supporting documentation such as d/c summary, labs, last office visit note and medication profile in your medical record.

Please complete and fax the following information (or attach demographics / face sheet) and office visit note to: **(818) 450-5440**

PATIENT

Patient Name: ____________________ SSN: ____________________

Date of Birth: ____________________ M ☐ F ☐ Address: ____________________

Phone: ____________________ City, State, Zip: ____________________

Alternate Contact Name: ____________________ Last Flu Vaccine Date: ____________________

Alternate Contact's ____________________ Referral Date: ____________________

Number: Primary Care ____________________ Insurance Information: ____________________ *(or attach copy)*

Physician: ____________________

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.)*

HgbA1C Date: ____________________ **HgbA1C Result:** ____________________

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 ENCOUNTER

I certify that this patient is under my care and that I, or a nurse practitioner or PA working with me or a physician who cared for the patient 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 homebound or requires a taxable effort to move around 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 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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