'Our Hearts are in your Home''

PATIENT REFERRAL FORM

PATIENT NAME:______________________________ DATE:______________________
ADDRESS:__________________________________ DOB: ______________________
__________________________________ PHONE: ______________________

MD NAME (Printed): ______________________________ MD PHONE:____________________
NAME OF PERSON REFERRING:____

INSURANCE

Plan#1: ______________________ Policy No:______________________ (e.g.) Medicare
Plan#2: ______________________ Policy No:________ ________________ (e.g.) AARP/Medical

EMERGENCY CONTACT

NAME:____ PHONE:______________________

PRIMARY DIAGNOSIS: ____

MEDICALLY NECESSATY HOME HEALTH CARE SERVICES:

☐ Skilled Nursing ☐ Physical Therapy ☐ Home Health Aide
☐ Occupational Therapy ☐ Speech Therapy ☐ Medical Social Work

IF PATIENT IS ON MEDICARE:

The F2F encountered date must be within 90 days prior or 30 days after the date of the home care admission and **related to the reason for the home care referral**

I certify that this patient is under my care and that I or a Nurse Practitioner or Physician's Assistant had a face to face encounter on MONTH :________________ DAY:_______ YEAR:___________.

IF PATIENT IS ON MEDICARE:

Certification of Home Health Services:
Based on the above finding, I certify this patient is confined to the home and needs intermittent skilled nursing, physical, speech or occupational therapy. The patient is under my care, and I have initiated the establishment and will periodically review the plan of care. I will provide the agency additional information to support the patient's homebound status and need for skilled care. Examples of this information could include physician progress notes, history and physical forms, operative reports, discharge summaries, etc.

PHYSICIAN SIGNATURE:_____________________________________DATE:______________________

Please return a copy of the office notes from the F2F encounter visit when returning this signed document.

☐ **CHECK BOX IF NEXT DAY VISIT NEEDED**

PLEASE CALL TO CONFIRM OUR RECEIPT OF THIS FAX
FAX LINE: (925) 684-4193
INTAKE PH 925-634-7878 OR TOLL FREE 866-442-6284