HOME HEALTH REFERRAL FORM

Referral Source: ____________________

Contact: ____________________ Phone: ____________________

Patient Name: ____________________ DOB: ____________________

Medicare #: ____________________

ORDERS

Diagnoses: ____________________

Home Health: ❑ Nursing ❑ PT ❑ OT ❑ ST ❑ SW ❑ HHA

Please include demographics, last clinical notes and H&P with current medication list.

❑ Fall Prevention	❑ CHF /COPD/HTN	❑ Cancer	❑ Other
❑ Low Vision	❑ Wound Care	❑ HIV/AIDS	
❑ Vestibular	❑ Dementia Care	❑ ESRD	
❑ Orthopedics	❑ Parkinson's Program	❑ ALS	____________
❑ Diabetes Mgmt/ Foot Care	❑ Neuro/Stroke	❑ Other	____________

EQUIPMENT NEEDS: ____________________

Face-to-Face to be completed by a physician or physician representative only,

FACE-TO-FACE (F2F)

F2F Date: *(M/D/YEAR)* ____________ The F2F encounter was in whole, or in part, for the following condition(s) which is the primary reason for home health:

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(conditions necessitating home health)

My clinical findings *(as identified at this encounter)* support this patient is homebound ***because*** *(provide narrative)*:

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My clinical findings (as identified at this encounter) support the need for skilled nursing and/or therapy services ***because*** *(provide narrative)*:

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Community Physician Certification Statement: *Based on the above findings, I certify that this patient is homebound, and needs intermittent skilled nursing, PT, and/or ST. The patient is under my care, and I will periodically revlew the plan of care.*

Inpatient Physician Certification Statement: *Based an the above findings, I certify that this patient is homebound, and needs intermittent skilled nursing, PT and/or ST. The patient is under my care, and I have Initiated the home health plan of care. This patient will be followed by a physician who will periodically review the plan of care.*

By signing below, physician authorizes orders and validates F2F. Please copy for your records.

____________________ *Physician Signature*

____________________ *Date of Signature*

____________________ *Physician Name (please print)*