inTouch Home Care Inc.
Care Perfected.

4701 Patrick Henry Drive, Suite 2601
Santa Clara, CA 95054
Phone: (408) 650-7110
Fax: (408) 608-1917

PATIENT REFERRAL FORM

PATIENT INFORMATION (please attach face sheet)			
Patient's First and Last Name:			☐ Male ☐ Female
Address:			
City:	Zip:	Phone:	
DOB:	SS#:	Alt. Phone:	
Primary Language (*if other than English*):			

INSURANCE INFORMATION (please attach insurance card copy)			
☐ Medicare#:		☐ Medi-Cal #:	
☐ Private Ins.:	ID#:	Group#:	Subscriber:

PERTINENT PATIENT HEALTH INFORMATION (please attach notes, medical history and/or medications)
Primary Dx:
Other Dx:
Surgeries/Procedures and Dates:
Medical Reason for Home Health Request:
Start of Care Date Requested:
Disciplines Requested: ☐ RN ☐ PT ☐ OT ☐ ST ☐ MSW ☐ HHA

☐ Remote Patient Monitoring: *No cost to patient, remote monitoring daily of vitals, along with wearable health button in the event of a fall or other emergency*

☐ Companion Care (Caregiver): *Out of pocket service for assistance ADLs, transportation, and companionship. Someone will contact your patient directly to set up a FREE, no obligation assessment to explain our services*.

PHYSICIAN INFORMATION	
Physician's Name:	
Address:	
City:	Zip:
Phone:	Fax:
NPI #:	UPIN #:

PHYSICIAN RESPONSIBILITIES

1. SIGN ORDERS: The Home Health Certification and Plan of Care (HCFA 485) required by regulation and for reimbursement. Physician signature is required on this form within 30 days of start of care home health services, and indicates physician's agreement that patient meets regulatory program criteria (homebound. skilled need, medical necessity).
2. CHANGE IN PLAN OF CARE: Additional orders by physician require signature within 30 days of order.
3. PHYSICIAN COVERAGE: When not available, please provide alternate physician coverage.
4. PROVISOIN OF HISTORY AND PHYSICAL REPORT: Required by CMS within 24 hours of start of care

I certify that this patient is under my care and that I, or a nurse practitioner or physician's assistant working with me or a physician who cared for the patient in an acute or post-acute facility had a face-to-face encounter related to the primary reason the patient requires home health that meets CMS requirements with this patient on _____.

(date the face-to-face visit occurred)

Physician Signature: _____ Date: _____