

PATIENT REFERRAL FORM

PATIENT INFORMATION (please attach face sheet)

Patient's First and Last Name:		<input type="checkbox"/> Male <input type="checkbox"/> Female
Address:		
City:	Zip:	Phone:
DOB:	SS#:	Alt. Phone:

INSURANCE INFORMATION (please attach insurance card copy)

<input type="checkbox"/> Medicare#:	<input type="checkbox"/> Medi-Cal #:		
<input type="checkbox"/> 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: <input type="checkbox"/> RN <input type="checkbox"/> PT <input type="checkbox"/> OT <input type="checkbox"/> ST <input type="checkbox"/> MSW <input type="checkbox"/> HHA

Companion Care (Caregiver): *Out of pocket/Long-term care insurance service for assistance with personal care, meal prep, light housekeeping, 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**
- 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).
 - CHANGE IN PLAN OF CARE:** Additional orders by physician require signature within 30 days of order.
 - PHYSICIAN COVERAGE:** When not available, please provide alternate physician coverage.
 - DRUG REGIMEN REVIEW:** Required by CMS within 24 hours of start of care, along with initial agreement to clinician plan 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: _____