"We only do ONE thing. Give H.O.P.E."

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HOME HEALTH REFERRAL FORM

Please admit the patient whose name is listed below to home health services:	
Patient Name:	DOB:
Address:	Medicare#: Insurance:
Tel.No.:	

PHYSICIAN VERIFICATION of FACE-TO-FACE ENCOUNTER

PHYSICIAN ATTESTATION

I certify that this patient is under my care and that I, a nurse practitioner or physician's assistant working with me, had face-to-face encounter with the patient on: _______________ (Date of MD visit).

The encounter with the patient was in whole, or in part, for the following condition, which is the primary reason for home health care *(List medical conditions/diagnosis. Example: Heart DZ, CAD, DM, HTN CVA, etc):*

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My clinical findings support the need for the following Home Health Services:

Nursing: For skilled assessment and evaluations of overall health status and body systems. Observation of vital signs, response to treatment / medications and proper management at home.

PT: Visit for home exercise program, safety measures, safe transfers & mobility and ambulation.

OT: For instruction in energy conservation and work simplification for ADLS.

ST: For swallowing difficulty, poor gag reflex, facial/tongue mobility & other communication deficits.

MSW: To obtain necessary community resources to enable the patient to remain at home, provide a brief therapy regarding management/adjustment to illness & facilitate coping with increased functional limitations.

CHHA: To assist patient with ADLS, personal care & hygiene, skin/foot care, grooming and light housekeeping.

OTHERS (Labs, IV, Wound Care): ____

My clinical findings support that this patient is homebound because: *(example: "leaving home is a taxing effort", "patient is unable to leave home unassisted or due to medical restriction")*

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I certify that the above-listed Home Health Services are required and authorized by me. The patient is under my care and is in need of skilled nursing care, may require physical, occupational, speech therapy, medical social services and HHA services on an intermittent basis. The medical treatment is reviewed every two (2) months.

PHYSICIAN SIGNATURE: ________________________________ DATE: ______________________

PHYSICIAN PRINTED NAME: ____