Home Health Care Referral Form

Office: 248-957-1999 Fax: 888-990-0589

Patient Information:

Name: ___________________________________

Address: _________________________________

City: ________________ State: ____ Zip: ______

Phone: __________________________________

DOB: ________________ SSN: ______________

Medicare # ______________________________

Patient's Primary Language: __________________

Primary Diagnosis: __________________________

____

Diabetes: Y/N _______________________________

Allergies: ___________________________________

Recent Vaccinations: PPV _______ Influenza_____

Current Medication List Included: Y/N

ORDERS:

- ☐ **Skilled Nurse** to Evaluate for Home Care Needs
- ☐ **Physical Therapy** Evaluation & Treatment
- ☐ **Occupational Therapy** Evaluation & Treatment
- ☐ **Speech Therapy** Evaluation & Treatment
- ☐ **Home Health Aide**
- ☐ **Dietician**
- ☐ **Medical Social Worker** Eval. For Community Resources

Lab Orders: _________________________________

Wound Care Orders: __________________________

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Other: ______________________________________

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Verbal Order Received By:_______________________________ Date:_____________

Face-to-Face Encounter

I certify that this patient is under my care and that I, or a nurse practitioner/clinical nurse specialist/certified nurse-midwife or physician assistant working in collaboration with me, had a face-to-face encounter with this patient. The encounter occurred on: ______/______/_______. **The encounter was related to the primary reason the patient requires home health care services.**

I will provide the agency additional information to support the patient's homebound status and need for skilled care. Examples of this information can include physician progress notes, history and physical forms, discharge summaries, etc.

Physician Signature: ____________________________________ **Date:** __________________________

Physician Printed Name/Credentials: ____

Legally Authorized Representative

- ☐ No Legally Authorized Representative (Guardian/ DPOA for Health Care)
- ☐ Legally Authorized Representative to sign Admission Consent/Home Care Documents
- ☐ DPOA States Patient can Sign Own Documents
- ☐ Requested Copy of Legally Authorized Representative's Legal Documents.

Name: _____________________________ **Relationship:** _________________ **Date:** _________________

Address: ____________________________ **City:** ___________________ **State:** _______ **Zip:** ____________

Phone: _____________________________ **Representative's Primary Language**:____________________