REFERRAL FORM

This form is designed to capture initial referral information. It is not intended to be all inclusive. CMS or insurer may require additional information such as medical records from Physicians. Please keep supporting documentation such as d/c summary, labs, last office visit note and medication profile in your medical record.

Please complete this information (or attach demographics /face sheet) and office visit note. **Fax** to: (210) 469-4026.

PATIENT

Patient Name:_____ SSN Last 4:_____

Date of Birth:_____ M ☐ F ☐ Address:_____

Phone_____ City, State, Zip:_____

Alternate Contact Name:_____ Last Flu Vaccine Date:_____

Alternate Contact's Number:_____ Referral Date:_____

Primary Care Physician:_____ Insurance Information:_____
(or attach copy)

Office Contact Name:_____ Office Contact Number:_____

DIAGNOSIS ICD-10-CM Codes / MEDICAL CONDITION: *(List the diagnosis / medical conditions primary to home health care.)*

HgbA1C Date:_____ **HgbA1C Result:**_____

SKILLED SERVICES / INTERVENTIONS: *(Describe services the nurse or therapist will perform in the home, e.g. assess, teach, wound care, gait training.)*

☐ Skilled Nursing for:_____ ☐ Occupational Therapy:_____

☐ Physical Therapy for:_____ ☐ Social Work:_____

☐ Speech Therapy for:_____ ☐ Home Health Aide:_____

ADDITIONAL ORDERS:_____

CERTIFICATION FOR FACE-TO-FACE ENCOUNTER

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 or insurer requirements with this patient on:

Face-to-Face Encounter Date _____ | _____ | _____

Based on the above findings, I certify that this patient is confined to the home and needs intermittent skilled nursing, physical therapy, and/or speech therapy. The patient is under my care and I have initiated the establishment of the plan of care for home health.

Physician's Name/NPI# : _____

Physician Signature: _____ Signature Date: _____

OPTIONAL PHYSICIAN DOCUMENTATION

This section is provided for the physician's convenience and record keeping in the event of a Medicare audit.

CLINICAL FINDINGS: *(Signs and symptoms of medical condition exhibited by the patient during the encounter that support the need for all services listed above.)*

HOMEBOUND STATUS: *(Describe the clinical and / or physical findings and the functional limitations that result in the patient's normal inability to leave home.)*