



# PATIENT REFERRAL FORM

Please complete and fax the following information (attach demographics / face sheet) and office visit note to the fax number above.

**PATIENT**

Patient Name: \_\_\_\_\_ Patient DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Patient Telephone #: \_\_\_\_\_ Primary Language \_\_\_\_\_

Patient Can Sign Own Consents:  Yes  No If no, is there a DPOA? \_\_\_\_\_

Referral Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Physician/Referral Source: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Emergency Contact #: \_\_\_\_\_

Insurance Information (or attach copy): \_\_\_\_\_

## ORDERS

**Patient's Primary Diagnosis / Reason the patient requires home health care** (Please be as specific as possible; symptom codes and ill-defined conditions are not allowed under coding guidelines)

**Specify here:** \_\_\_\_\_

**Check primary discipline being ordered and the reason(s) why in the space provided:**

- Skilled Nursing \_\_\_\_\_
- Behavioral Health \_\_\_\_\_
- Physical Therapy \_\_\_\_\_
- Social Work \_\_\_\_\_
- Speech Therapy \_\_\_\_\_
- Occupational Therapy \_\_\_\_\_
- Home Health Aide \_\_\_\_\_
- Palliative Care \_\_\_\_\_  
(RN, MSW, Palliative Care MD PRN for symptom management)

**Must complete both sections below to meet homebound eligibility criteria.**

**1. Patient requires the following assistance to leave the home: (check all that apply)**

- Cane
- Walker
- Wheelchair
- Aid of another person

**2. Patient cannot leave the home or requires assistance to leave the home because (check all that apply):**

- High fall risk due to gait instability
- Medically Contraindicated
- Muscle weakness
- Cognitive deficits impact judgment, impair ability to safely navigate and prevent decision-making for safety
- Shortness of breath/distress after ambulation more than 10 feet results in high risk for falling
- Recent lower/upper extremity surgical procedure results in instability, weakness, non-weight bearing, and/or pain with ambulation
- Patient is bedbound due to: \_\_\_\_\_

\*Homebound Status (required for Home Health order): Due to the above stated illness, injury, or surgical procedure (medical condition or diagnosis) and associated clinical findings, the patient is homebound because of his/her inability to leave the home except with the aid of a supportive device and/or person AND leaving the home requires a considerable and taxing effort or is medically contraindicated.

## FACE-TO-FACE ENCOUNTER

Face-to-Face Encounter Date (or scheduled): \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Face-to-Face Attached:

Most recent visit:  Office  Telehealth

**Based on the above findings, I certify that this patient is confined to the home and authorize to evaluate and admit the patient. The patient is under my care and I have initiated the establishment of the plan of care for home health.**

Physician's Name (Please Print): \_\_\_\_\_ Physician Phone: \_\_\_\_\_

**Physician's Signature:** \_\_\_\_\_ **Signature Date:** \_\_\_\_\_

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