DATE: ________________

REFERRAL COORDINATOR: ________________ PHYSICIAN: ________________

FACILITY: ________________ EXPECTED DISCHARGE: ________________ # OF DAYS IN FACILITY: ________

PATIENT NAME: ________________ DOB: ____________ SS #: ________________

ADDRESS: ________________ TELEPHONE # ________________

EMERGENCY CONTACT: ________________ RELATIONSHIP: ____________ TELEPHONE # ____________

ADDITIONAL CONTACT: ________________ RELATIONSHIP: ____________ TELEPHONE # ____________

MEDICARE # ________________ INSURANCE NAME: ________________ TELEPHONE # ____________

MEDICAID # ________________ INSURANCE NAME: ________________ TELEPHONE # ____________

OTHER INSURANCE: ________________ POLICY # ________________ GROUP # ____________

PHYSICIAN NAME: ________________ TELEPHONE # ________________ FAX # ____________

NPI: ________________ LICENSE # ________________

MD Referral Order: ____

____

PLEASE INCLUDE THE FOLLOWING WITH REFERRAL:
HISTORY & PHYSICAL OR RECENT PROGRESS NOTES AND MEDICATION LIST

FACE TO FACE ENCOUNTER

I certify this patient is under my care and that, I or a nurse practitioner or physician's assistant working with me, had a face-to-face that meets the physicians face-to-face encounter requirements with this patient on (last MD apt.): _____ / _____ / _____.

The encounter with the patient was in whole, or in part, for the following medical condition. which is primary reason for home health care (list medical condition):____.
I certify that based on my findings, the following services are medically necessary home health services (select all that apply:

____ **Skilled Nursing** ____ **Home Health Aid** ____ **Medical Social Work**

____ **Physical Therapy** ____ **Occupational Therapy** ____ **Speech Therapy**

To provide the following care/treatments:

____. My clinical findings support the need for the above services because:____.

Further, I certify that my clinical findings support that this patient is homebound because (i.e., needs assistance for all activities, taxing effort to leave home, unsafe to go home alone, severe SOB, unable to leave home unassisted and/or any other clinical factors):____

____

PHYSICIAN NAME (Printed): ________________________________

PHYSICIAN SIGNATURE: ________________________________ DATE: ________________