Home Health Fax Referral

Patient Name: ______________________ **DOB:** ____________ **SSN:** ______________

Address: ____

City: ______________________ **State:** ____________ **Zip:** ____________

Medicare #: ______________ **Insurance Name / ID #:** ______________________ **Phone #:** ____________

Orders: ____

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❑ SN ❑ PT ❑ ST ❑ OT ❑ HHA ❑ MSW

Verification Date

I certify that this patient is under my care and that I, a nurse practitioner, or physician's assistant working with me, had an encounter with this patient that meets the physician face-to-face encounter requirements on:

____
Month Day Year

Medical Condition

At least one of the medical reasons / diagnoses / conditions for this patient encounter was related to the primary reason for home care.

Specify condition(s) related to home care orders: ______________________________

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Clinical Findings

The following clinical findings support the need for home care: ______________________________

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Service Needed

The patient's clinical findings support the orders for the medically necessary home care service(s).

Homebound Status

I certify that the clinical findings support that this patient is homebound (i.e., absences from home require considerable and taxing effort and are for medical reasons, attending religious services, or for other non-medical reasons which are infrequent or of short duration) due to:

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Physician Signature: ______________________________ **Date:** ______________