Tel: 747 877 9077
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213 W Alameda ave Suite 103
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PATIENT REFERAL FORM

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

GENERAL INFORMATION

Referal Date_____ Physician/Referal Source:_____

Referal Source Tel #:_____ Fax #:_____

*Insurance Information(or attach copy):*_____

☐ Medicare Number_____

☐ Other(name and number) _____

PATIENT INFORMATION

Patient Full Name:_____

Patient Tell #:_____ Emergency Tell #:_____

Address:_____ City:_____ State:_____ Zip:_____

Emergency Contact Name:_____ Relationship_____

Patient Can Sign Own Consents: ☐ **Yes** ☐ **No** | Patient has DPOA: ☐ **Yes** ☐ **No** | Patient is Homebound: ☐ **Yes** ☐ **No**

ORDERS

Patient's Primary Diagnosis / Reason the patient requires home health care

Specify here:_____

_____

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

☐ Skilled Nursing_____
☐ Home Health Aide_____
☐ Social Work_____
☐ Ocupational Therapy_____
☐ Physical Therapy_____
☐ Speech Therapy_____
☐ Other(please specify)_____

Patient requires the following care:(check all that apply)

☐ Wound Care ☐ IV Therapy ☐ PICC Line Care ☐ FOLEY Care
☐ Wound Vac ☐ TPN ☐ Peripheral IV ☐ Other (Please specify)_____

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:_____ Physician Phone:_____

Physician's Signature:_____ Signature Date:_____