

HOME CARE REFERRAL ORDERS

FAX COMPLETED FORM TO INTAKE: **850-430-1338**

REFERRAL DATE: _____ OFFICE CONTACT: _____

PHYSICIAN NAME: _____ PHONE: _____

NPI#: _____



PATIENT INFORMATION

LAST NAME	FIRST NAME	SEX	TELEPHONE #
		<input type="checkbox"/> M <input type="checkbox"/> F	

ADDRESS	CITY	STATE	ZIP CODE
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DATE OF BIRTH	SOCIAL SECURITY #	HEIGHT	WEIGHT	ALLERGIES
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DIAGNOSIS/Reason for Home Care:	Orders:
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Programs:

Walk Steady - Skilled Nursing and Physical Therapy for Evaluation and Treatment to assess balance/gait/safety issues, medication teaching

Healing Hearts At Home - Cardiac Care Program- Skilled Nursing and Physical Therapy for Evaluation and Treatment to educate patients about the disease, symptoms, home exercise program and proper diet, and medication teaching

In- Control Diabetic Care Program- Skilled Nursing for Evaluation and Treatment including Education, Medication Management, Nutritional Education

In- Home Neuro Rehab Program (CVA)- Skilled Nursing, Physical, Occupational, and Speech Therapy Evaluation and Treatment.

Wound & Ostomy Care- Skilled Nursing for wound care management and treatment. Wound VAC certified nurses and WOCN available.

In-Home Anti-Coagulation Program- Skilled Nursing for management of medication and disease process.

VitalStim- Speech Therapy for management of swallowing difficulties.

Skilled Service:

Skilled Nursing

Physical Therapy

Occupational Therapy

Speech Therapy

* Please send copy of last visit note, if available.

NEAREST RELATIVE, CAREGIVER OR CONTACT:

NAME:	PHONE:
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INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY/POLICY #	SECONDARY INSURANCE COMPANY/POLICY #
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CMS REQUIRES PHYSICIAN DOCUMENTATION OF FACE TO FACE

I certify that this patient is under my care and had a Face to Face encounter related to the primary reason for Home Health Services, with myself or non-physician (NP/Clinical Nurse Specialist/PA) within 90 days prior of the Start of Care for Home Health Services.

1) Date of Face to Face encounter: _____ / _____ / _____
Month Day Year

2) My clinical findings support the need for the above Home Health Services because:

3) Further, I certify that my clinical findings support this patient is homebound (leaving the home requires a considerable taxing effort) **because:**

PHYSICIAN SIGNATURE: _____ DATE: _____