



Patient Referral Form

FAX REFERRALS TO: 1-855-862-2244
OR CALL US AT: 1-855-862-2212
 HOME HEALTH HOSPICE

PATIENT INFORMATION

Name: _____

Address: _____

City/State/Zip: _____

Phone: _____	Date of Birth: _____
Social Security #: _____	Medicare #: _____
Health Plan: _____	Health Plan ID#: _____

Date Last Seen by Physician: _____

Diagnosis: _____

Surgery Date: _____	Hospital: _____
---------------------	-----------------

HOME HEALTH ORDER:	Frequency:	Duration:	ANY SPECIFIC ORDERS:	HOSPICE ORDER:
<input type="checkbox"/> Skilled Nursing				<input type="checkbox"/> Hospice Evaluation (And admit if appropriate)
<input type="checkbox"/> Occupational Therapy				
<input type="checkbox"/> Respiratory Therapy				
<input type="checkbox"/> Physical Therapy				
<input type="checkbox"/> Speech Therapy				
<input type="checkbox"/> Home Health Aide				
<input type="checkbox"/> Medical Social Work				
<input type="checkbox"/> Nutrition Evaluation				

If patient's primary insurance is TRADITIONAL MEDICARE, please complete this section.

Date of last FACE to FACE encounter: _____

Traditional Medicare patients are required to have a face to face encounter with a Physician, APRN or PA within 90 days prior to or within the 30 days following the start of home care. Must be related to reason for homecare.

Specify clinical deficits that require skilled intervention (do not list Diagnosis): _____

A brief description of the patients homebound status include contributory clinical/functional deficits and any assistive devices or person needed: _____

Physician Signature: _____	Date: _____
Physician Printed Name: _____	
Phone: _____	FAX: _____

CONFIDENTIALITY NOTICE: HIPAA PROTECTED HEALTH INFORMATION ENCLOSED
 Protected Health Information (PHI) is personal and sensitive information related to a person's health care. It is being faxed to you after appropriate authorization from the patient or under circumstances that do not require patient authorization. You, the recipient, are obligated to maintain it in safe, secure and confidential manner, re-disclosure without additional patient consent or as permitted by law is prohibited. Unauthorized re-disclosure or failure to maintain confidentiality could subject you to penalties described in federal and state law.
IMPORTANT WARNING: This message is intended for the use of the person or entity to which it is addressed and may contain information that is privileged and confidential, the disclosure of which is governed by applicable law. If you are not the intended recipient, or the employee or agent responsible to deliver it to the intended recipient, you are hereby notified that any disclosure, copying or distribution of this information is strictly prohibited. If you have received this message by error, please notify the sender immediately to arrange for return or destruction of these documents.

BD 103: 4.2015 v2