QUICK-FAX HOME HEALTH REFERRAL FORM

FAX THIS FORM TO: ☐ MONTEREY: 831-646-8246 ☐ FRESNO: 559-226-2038

To expedite this referral, please send: Face Sheet, H&P, current Medication list, copy of Insurance Card

Patient Name: _____
Address: _____
_____
Phone: _____
Diagnosis: _____
Insurance: ☐ Medicare ☐ Other _____
DOB: _____ SSN#: _____

Doctor/Facility: _____
Contact Name: _____
Date: _____ Total # of pages: _____
Fax #: _____
Phone #: _____

Date of encounter: I certify that this patient is under my care and that I, my nurse practitioner or physician's assistant, had a face-to-face encounter on _____/_____/_____.

Reason for encounter/clinical findings: The encounter with the patient was in part/whole to address the following medical condition/s, which is the primary reason for home health care: _____
_____

The patient is homebound, requiring considerable and taxing effort to leave home as manifested by:
(May include physical conditions, mental impairments, physician-ordered restrictions, weakness, SOB, infection risk):
_____
_____

I certify that, based on my findings, the following services are medically necessary (check all that apply):

Skilled Nursing **Assess & instruct for:**	Physical Therapy **Eval & treat for:**	Speech Therapy **Eval & treat for:**
☐ Medication Mgmt. ☐ Pain ☐ Cardiac ☐ Diabetic Mgmt. ☐ Respiratory ☐ Wound ☐ IV ☐ Other	☐ Weakness ☐ Ambulation/Gait Training ☐ Transfers ☐ Total Hip Protocol ☐ Total Knee Protocol ☐ Balance ☐ Fall Risk/Injury ☐ Range of Motion ☐ Other	☐ Swallowing ☐ Impaired Cognition ☐ Alternate Communication Need ☐ Other ☐ Dysphasia ☐ Dysphagia

Additional services needed: ☐ Occupational Therapy ☐ MSW ☐ Home Health Aide

Additional Orders: _____
_____

☐ **COMPANION CARE (CAREGIVER):** *Out of pocket/Long Term Care Insurance service for assistance with personal care, meal prep, light housekeeping, transportation and companionship.*

- *Someone will contact your patient directly to set up a FREE, no obligation assessment to explain our services.*

Physicians Signature: _____ **Date:** _____

FAX TO: FRESNO (559) 226-2038 • Telephone: (559) 248-0131 • Email to: intakefresno@healthinhome.com
MONTEREY (831) 646-8246 • Telephone: (831) 646-2046 • Email to: intakemonterey@healthinhome.com

Facility use only: Phone orders received by: _____ Verbal orders from Dr._____