FAX REFERRAL FORM

Patient Name: ______________________________
Phone: ______________________________
Insurance: ☐ Medicare ☐ Medicaid ☐ Other
ID #______________________________
DOB: ______________ SSN#: ______________
Diagnosis: ______________________________

Doctor/Facility: ______________________________
Contact Name: ______________________________
Date: ______________ Total # of pages: ______________
Fax #: ______________________________
Phone #: ______________________________
Emergency Contact: ______________________________

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

Skilled Nursing	Physical Therapy	Occupational Therapy	Speech Therapy
☐ Medication	☐ Weakness	☐ ADL Training	☐ Swallowing
☐ Pain	☐ Ambulation/Gait Training	☐ Energy Conservation	☐ Impaired Cognition
☐ Chronic Disease Management	☐ Transfers	☐ Upper body strengthening	☐ Dysphasia
☐ Education	☐ Total Hip Protocol	☐ Eval & Training with Assistive Devices	☐ Dysphagia
☐ Wound	☐ Total Knee Protocol	☐ Safety in the home	☐ Alternate Communication Need
☐ IV	☐ Balance	☐ Developmental Disorder	☐ Other
☐ Other	☐ Fall Risk/Injury	☐ Other	
	☐ Range of Motion		
	☐ Other		

Additional services needed: ☐ MSW ☐ Home Health Aide

Orders: ______________________________

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Date of face to face 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 ____/____/____.

☐ The patient has not been seen within the last 90 days for the primary condition. If not seen or if the last visit was longer than 90 days ago, an appointment must be made and the encounter documented within 30 days.

Reason for encounter & clinical findings: The encounter with the patient was in part/whole to address the following medical condition/s/diagnosis/s, which is the primary reason for home health care. (**List diagnosis and findings**): ______________________________

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Homebound Status – Must meet at least one from Criteria 1 and both from Criteria 2 below:

Criteria 1 *(must meet at least one)*

Due to illness or injury, the patient needs:

☐ The aid of supportive devices (crutches, cane, wheelchair, walker);

☐ The use of special transportation; or

☐ The assistance of another person to leave home.

And/Or

☐ Have a condition such that leaving home is medically contraindicated.

Criteria 2 *(must meet both of these criteria)*

☐ The patient has a normal inability to leave home; and,

☐ Leaving home requires a considerable and taxing effort.

Physicians Signature: ______________________________ **Date:** ______________

Please fax these *essentials*: Face Sheet • Copy of Insurance Card • History & Physical

FAX To: (501) 321-9567 • Telephone: (501) 321-0708