



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
<input type="checkbox"/> Medication <input type="checkbox"/> Pain <input type="checkbox"/> Chronic Disease Management <input type="checkbox"/> Education <input type="checkbox"/> Wound <input type="checkbox"/> IV <input type="checkbox"/> Other	<input type="checkbox"/> Weakness <input type="checkbox"/> Ambulation/Gait Training <input type="checkbox"/> Transfers <input type="checkbox"/> Total Hip Protocol <input type="checkbox"/> Total Knee Protocol <input type="checkbox"/> Balance <input type="checkbox"/> Fall Risk/Injury <input type="checkbox"/> Range of Motion <input type="checkbox"/> Other	<input type="checkbox"/> ADL Training <input type="checkbox"/> Energy Conservation <input type="checkbox"/> Upper body strengthening <input type="checkbox"/> Eval & Training with Assistive Devices <input type="checkbox"/> Safety in the home <input type="checkbox"/> Developmental Disorder <input type="checkbox"/> Other	<input type="checkbox"/> Swallowing <input type="checkbox"/> Impaired Cognition <input type="checkbox"/> Dysphasia <input type="checkbox"/> Dysphagia <input type="checkbox"/> Alternate Communication Need <input type="checkbox"/> Other

Additional services needed: MSW Home Health Aide

Orders: _____

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):** _____

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: (479) 964-5653 • Telephone: (479) 968-4544