TRINITY
Home Health of Arkansas
Compassion • Integrity • Excellence

FAX REFERRAL FORM

Patient Name: _____ Doctor/Facility: _____
Phone: _____ Contact Name: _____
Insurance: ☐ Medicare ☐ Medicaid ☐ Other Date: _____ Total # of pages: _____
ID #_____ Fax #: _____
DOB: _____ SSN#: _____ Phone #: _____
Diagnosis: _____ 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	☐ Ambulation/Gait Training	☐ ADL Training	☐ Swallowing
☐ Pain	☐ Transfers	☐ Energy Conservation	☐ Impaired Cognition
☐ Chronic Disease Management	☐ Total Hip Protocol	☐ Upper body strengthening	☐ Dysphasia
☐ Education	☐ Total Knee Protocol	☐ Eval & Training with Assistive Devices	☐ Dysphagia
☐ Wound	☐ Balance	☐ Safety in the home	☐ Alternate Communication Need
☐ IV	☐ Fall Risk/Injury	☐ Developmental Disorder	☐ Other
☐ Other	☐ Range of Motion	☐ Other	
	☐ 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

Central
Fax: 501.321.9567
Phone: 501.321.0708

North
Fax: 870.932.0450
Phone: 870.932.7463

River Valley
Fax: 479.439.5461
Phone: 479.662.4040

South
Fax: 870.836.1371
Phone: 870.836.1301