Home Health
Specialty Services

PATIENT REFERRAL FORM

Patient Name: _____ **Date:** _____

Address: _____ **DOB:** _____

_____

Phone: _____ **Alt:** _____

Community MD (Printed): _____

MD Phone: _____ **Person Referring:** _____

Insurance:

Plan #1: _____ Policy No.: _____

Plan #2: _____ Policy No.: _____

Emergency Contact:

Name: _____ Phone: _____

Relationship: _____

Primary Diagnosis: _____**Secondary Diagnosis:**_____

Medically Necessary Home Health Services:

☐ **Skilled Nursing**	☐ **Physical Therapy**	☐ **Occupational Therapy**
☐ **Speech Therapy**	☐ **Medical Social Worker**	☐ **Home Health Aide**

If Patient is on MEDICARE:

The F2F encounter date must be within 90 days prior or 30 days after the date of the home care admission and related to the reason of why homecare is being ordered.

I certify that this patient is under my care and that I or a Nurse Practitioner or Physician's Assistant had a face to face encounter on: Month: _____ Day: _____ Year: _____

Certification of Home Health Services:

Based on the above findings, I certify this patient is confined to the home and needs intermittent skilled nursing, physical, occupational, or speech therapy. The patient is under my care, and I have initiated the establishment and will periodically review the plan of care. I will provide the agency additional information to support the patient's homebound status and need for skilled care. Examples of this information could include physician progress notes, history and physical forms, operative reports, discharge summaries, etc.

PHYSICIAN SIGNATURE: _____ DATE: _____

PLEASE CALL TO CONFIRM OUR RECEIPT OF THIS FAX

FAX LINES: 203-288-8205 INTAKE LINES: 203-288-8200

Please attach current medication list, last physician visit note or W10