REFERRAL FORM/PHYSICIAN ORDER/FACE-TO-FACE

TEL: (214)363-2559 FAX: 1(866)540-1396 or (214)431-4671

	Fax Included:
From: ______________________________	☐ Face Sheet
	☐ Demographics
Referred by: ______________________________	☐ H & P
	☐ Physician order
Tel: ________________ **Fax:** ________________	☐ DC Summary
	☐ Rx List
Date: ________________	☐ Face-to-face encounter
	☐ Others: ________________

Patient Information:

Name: ______________________________ SSN#: ________________ Gender: F ☐ M ☐

Tel: ________________ Alternate #: ________________ DOB: ________________

Address: ____

Insurance Information:

☐ Medicare#: ________________ ☐ Others: ______________________________

My clinical findings support that this patient is homebound and meets the need for the below services because:
☐ See attached physician notes ☐ Detail explanation: ______________________________
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HOME HEALTH ORDER	SPECIALTY PROGRAM	
☐ Skilled Nursing	☐ Cardiovascular Care	☐ Orthopedic Care
☐ Physical Therapy	☐ CHF care(LVAD, IV Inotropes)	☐ Ostomy Care
☐ Occupational Therapy	☐ Diabetic care	☐ Post Surgical Care
☐ Speech Therapy	☐ Infusion Therapy	☐ Respiratory (COPD, PNA, Vent)
☐ MSW	☐ Medication Management	☐ Strength/Balance Program
☐ Home Health Aide	☐ Neurological care (Stroke, MS)	☐ Transplant care
☐ Others: ________________	☐ Oncology care	☐ Wound Care

Detailed Orders: ____
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I certify that this patient is under my care and that I, or a nurse practitioner or physician's assistant working with me, had a face-to-face encounter that meets the physician face-to-face encounter requirements with this patient on (**Insert date that visit occurred**):______________________________ . I certify that, based on my findings, the above services are medically necessary home health services.

Physician Signature: ______________________________Date: ________________

Physician Printed Name: ____