Home Health Care Referral Form

Intake Fax: 248-649-5417   Phone: 800-439-0840

Patient Name: ______________________________ DOB: ________________ M / F

Address: ____

City / Zip: ______________________________ Phone: ____________________

Insurance Provider: __________________________ ID # ____________________

Emerg. Contact/Caregiver: _____________________ Phone: ____________________

Diagnosis: 1. ______________ 2. ______________ 3. ______________ 4. ______________

Reason for Home Care: ____

Urgency of referral: ☐ Same Day ☐ Within 24 hours ☐ Within 3 days ☐ Within 1 week

Services Desired: ☐ Skilled Nursing ☐ Occupational Therapy ☐ Physical Therapy ☐ Speech Therapy
☐ Cardiac Care ☐ Wound Care ☐ Home Health Aide ☐ Social Work

Referring Physician: ______________________________ NPI: ____________________

Address: ______________________________ City & Zip: ____________________

Office Phone: ______________________ Office FAX: ______________________

PLEASE ATTACH the following Medicare <u>Required</u> Supportive Documentation

- History and physical
- Medication list
- Face to Face (F2F) Encounter documentation: Date of F2F Encounter: ____ / ____/ ____
  - Progress Note, and/or
  - Visit Note, and/or
  - Consultation report

(must be within 90 days prior or 30 after the start of homecare)

We appreciate your business and look forward to serving your patient with our highly trained staff that combines caring services and technology to treat the person as a whole