Referral Form

<table>
<tr><td>Patient Contact</td><td colspan="2">Last:________________ First:________________ Middle:________________
Birth Date:____________ Gender: ☐ Male ☐ Female ☐ Other: ______________
Marital Status:__________ Email:________________________
Phone: ____________ Type: ☐ Home ☐ Cellular ☐ Contact # (no patient phone) ____________
Mailing Address:________________________ City:______________
State:__________ Zip:______________ County:______________
☐ Treatment Address same as Mailing Address (if no, add):
____
Emergency Contact: ____________________ Phone:____________
Power of Attorney (if applicable): ______________ Phone: ____________
Legal Guardian: ____________________ Phone: ____________
Health Care Proxy: ______________ Phone: ____________ Invoked? ☐ Yes ☐ No</td></tr>
<tr><td>Insurance</td><td>Primary Insurance:________________
Group # ____________
Policy # ____________
Patient’s Relationship to PolicyHolder:
________________</td><td>Secondary Insurance:________________
Group # ____________
Policy # ____________
Patient’s Relationship to PolicyHolder:
________________</td></tr>
<tr><td>Physician/ Practitioner</td><td colspan="2">Check which physician is the <u>certifying physician</u> that has agreed to follow the patient for home health. Complete all physicians known.
☐ Referring Physician/Provider: ____________________ Phone:____________
☐ Primary Care Physician: ____________________ Phone: ____________
☐ F2F Encounter Physician: ____________________ F2F Date: ____________
☐ F2F Encounter Requests Home Care Services ☐ Yes ☐ No Skill: ____________
☐ Has not occurred (must occur within 30 days of HH admission)</td></tr>
<tr><td>Referral Information</td><td colspan="2">Primary Diagnosis (including medical conditions):
____
____
Secondary Diagnoses (List all that apply):
____
____</td></tr>
</table>

Phone: (508) 827-7954 **Fax:** (800) 508-0614

<table>
<tr><td></td><td>Does the patient have any history of violence? ☐ Yes ☐ No

Does the patient's diagnosis' support the need for Home Care Services: ☐ Yes ☐ No

Does the skill requested support the diagnosis': ☐ Yes ☐ No

Eval and Treat (check all that apply): ☐ SN ☐ OT ☐ Home Health Aide ☐ Wound Care

Additional Orders:____

Wound Care Supplies:

____

____

Referral Source has ordered Wound Care Supplies: ☐ Yes ☐ No

Projected Frequency: ________________________

Specific Start of Care Date (if applicable): _______________

Homebound Status: ________________________

Are all elements of Homebound Status present? ☐ Yes ☐ No</td></tr>
<tr><td>Admission/ Referral Source</td><td>☐ Institutional Admission (Patient is being admitted directly from):_____________________________________
Phone: _______________________ Fax: ________________________
Type: ☐ LTC ☐ SNF ☐ IPPS ☐ LTCH ☐ IRF ☐ Psychiatric Unit
☐Other:______________________________ ☐ Patient had an acute or post-acute stay in the last 14 days
☐ Community: ____ Phone: _______________
Person Calling in Referral (name): ____
Phone: ______________________________ Email: _______________________________________</td></tr>
<tr><td>Additional Information</td><td>FAX TO: 800-508-0614
WITH COPIES OF: PATIENT SUMMARY/DEMOGRAPHICS, LAST VISIT NOTE(S) OR DISCHARGE SUMMARY, MEDICATION LIST, ALLERGIES, A DIAGNOSIS LIST ALONG WITH ICD-10 CODES AND ANY UPCOMING APPOINTMENTS THE PATIENT MAY HAVE</td></tr>
</table>

Physician Signature:____Date:________________________