Home Health Referral Form

Brookestone Home Health & Hospice

CMS may request medical records from Physicians. Please retain supporting documentation such as d/c summary, labs, last office visit note and medication profile in your medical record.

Please complete and fax the following information (or attach demographics/face sheet) and office visit note to: 308-210-3553

PATIENT

Patient Name: _____ Gender: ☐ M ☐ F DOB: _____

SSN: _____ Patient's Ph. #: _____

Patient's Address: _____ City: _____ State: _____ Zip: _____

Last Flu Vaccine Date: _____ Referral Date: _____

Alternate Contact Name: _____ Alternate Contact #: _____

Primary Care Provider: _____ Insurance Information: _____ *(or attach copy)*

Office Contact Name: _____ Office Contact Ph. #: _____

Diagnosis/Medical Condition: *List the diagnosis/medical conditions that are the primary reason the patient requires home health services.*

HgbA1C Date: _____ **HgbA1C Result:** _____

Skilled Services/Interventions: *describe services the nurse or therapist will perform in the home, e.g. assess, teach, wound care, gait training.*

☐ Skilled Nursing for: _____ ☐ Occupational Therapy: _____

☐ Physical Therapy for: _____ ☐ Social Work: _____

☐ Speech Therapy for: _____ ☐ Home Health Aide: _____

Additional Orders: _____

CERTIFICATIONS FOR FACE-TO-FACE ENCOUNTER

I certify that this patient is under my care and that I, or a physician assistant (PA) / nurse practitioner (APRN) working with me or a physician who cared for the patient in an acute or post-acute facility had a face-to-face encounter related to the primary reason the patient requires home health that meets CMS requirements with this patient on:

Face-to-Face Encounter Date: _____/_____/_____

Based on the above findings, I certify that this patient is confined to the home and needs intermittent skilled nursing, physical therapy, and/or speech therapy. The patient is under my care and I have initatied the establishment of the plan of care for home health services.

Physician Signature: _____ **Date**: _____

Physican Name (Print): _____

OPTIONAL PHYSICIAN DOCUMENTATION

This section is provided for the physician's convenience and record keeping in the event of a Medicare audit

Clinical Findings:
Signs and symptoms of medical condition exhibited by the patient during the encounter that support the need for all services listed above.

Homebound Status:
Describe the clinical and/or physical findings and the functional limitations that result in the patient's normal inability to leave home

Brookestone Home Health & Hospice

We look forward to serving you and your patients.

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