

## Home Health Referral Form

<p><b>Demographic Info</b> (Fax Demo sheet or fill in below)</p> <p>Patient Name _____</p> <p>Address _____</p> <p>Phone: _____</p> <p>SSN: _____</p> <p>DOB: _____</p> <p>Sex: M or F</p>	<p><b>Insurance Info</b></p> <p>Primary Ins _____</p> <p>ID# _____</p> <p>Policy# _____</p> <p>Group _____</p> <p>Medicare # _____</p> <p>Medicaid # _____</p> <p>Pro Bono Patient <input type="checkbox"/></p>
--	---

<p><b>Physician Signing Orders</b></p> <p>Name _____</p> <p>Phone _____</p> <p>Fax _____</p>	<p><b>Primary Dx(s)</b> (fax pertinent history, last physician note and medication sheet if available)</p> <p>_____</p> <p>_____</p> <p>_____</p>
--	---

Reason for Referral / Special Orders:

\_\_\_\_\_

\_\_\_\_\_

**Discipline(s) Ordered (Check all that apply):**

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

**Medicare | Traditional Medicaid | Pro Bono Patients Only**

Homebound: Due to the above stated illness, injury or surgical procedures (medical condition or diagnosis) and associated clinical findings, I certify that the patient is homebound because of his/her inability to leave the home except with the aid of a supportive device and/or person AND leaving the home requires a considerable and taxing effort or is medically contraindicated

Physician Signature: \_\_\_\_\_ Date \_\_\_\_\_

*\*Physician signature/order can be obtained from discharge summary or sent separately if applicable*

\_\_\_\_\_

Signature of Person Completing Form \_\_\_\_\_ Date \_\_\_\_\_