Standards
HOME HEALTH™
Raising the Standards in Health Care

RAPID REFERRAL

www.StandardsHomeHealth.com

REFERRAL INFORMATION

FAX: (888) 553-7575 OR (254) 778-7010

Patient Name: _____ Date of Birth: _____
Address: _____ Patient Phone: _____
_____ Alternate Phone (Cell): _____
Alternate Contact: _____ Phone: _____ Cell: _____
Social Security #: _____
Insurance Carrier Name: _____ Policy #: _____
Medicare #: _____
Services/ Programs: _____ Evaluate & Treat _____ SN _____ PT _____ OT _____ ST _____ MS _____ HHA
_____ Wound Care _____ PT/INR _____ TKA/THA _____ IV Therapy
Physician Orders/Instructions (Please include specific wound care & IV orders if applicable):

_____

_____

Physician's Signature: _____ **Date:** _____

FACE-TO-FACE DOCUMENTATION

I certify that this patient is under my care and that I, a nurse practitioner, clinical nurse specialist, or physician's assistant working with me, had a face-to-face encounter that meets the Medicare physician face-to-face encounter requirements.

Date of Face-to-Face: _____

The encounter with the patient was related to the following medical condition(s), which is the primary reason for home healthcare:

_____

_____

_____

I certify that based on my findings, the following services are medically necessary home health services (Check all that apply):

_____ SN _____ PT _____ OT _____ ST or Other: _____

Clinical findings that support the need for home health: _____

_____

_____

I certify in the Narrative below that my clinical findings support that this patient is home bound because (i.e., absences from home require considerable and taxing effort, are infrequent or of short duration, or are attibutable to the need to receive heatlh care):

_____

_____

_____

Physician's Signature: _____ **Date:** _____

Physician's Printed Name: _____