|  |  |  |  |
| --- | --- | --- | --- |
|  | **Corporate Office:**410 Corporate Center DriveVandalia, OH 45377 | **North Office:**423 N. Wayne StreetPiqua, OH 45356 | **South Office:**445 Byers RoadMiamisburg, OH 45342 |

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| **REFERRAL FAX: 937-264-3159** | **QUICK REFERRAL FORM** | **MAIN PHONE: 937-264-3155** |

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| Referral Date: |       | Provider Name: |       |
| Office Contact: |       | Phone Number: |       |

|  |  |  |
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|  | **PATIENT DEMOGRAPHICS & INSURANCE** |  |

|  |  |  |  |
| --- | --- | --- | --- |
| First Name: |       | Last Name: |       |
| Address: |       |
| Phone: |       | Sex: [ ]  M [ ]  F  | Date of Birth: |       /       /       |
| Known Allergies: |       | HT: |       | WT: |       |
| Diagnosis: |       |
| Primary Insurance: |       | Policy Number: |       |
| Secondary Insurance: |       | Policy Number: |       |
| Emergency Contact: |       | Relation: |       | Phone: |       |

|  |  |  |
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|  | **PROVIDER ORDERS** |  |

[ ]  Medication Management [ ]  Occupational Therapy [ ]  Physical Therapy [ ]  Speech Therapy

[ ]  Skilled Nursing [ ]  Wound Care [ ]  PT/INR [ ]  Personal Care / Aide

|  |  |
| --- | --- |
| Additional Comments / Orders: |       |

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|  | **CMS REQUIRES PROVIDER DOCUMENTATION OF FACE-TO-FACE** |  |

I certify that this patient is under my care and had a face-to-face encounter related to the primary reason for Home Health Services, with myself or non-physician (NP/Clinical Nurse Specialist / PA) within 90 days prior of the Start of Care for Home Health Services.

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| --- | --- | --- |
| Date of Face to Face Encounter: |       /       /       | \*Please send clinical notation from the encounter. |

Document clinical conditions / diagnosis causing patient to be homebound (Medicare only):

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|       |

Further, I certify that my clinical findings support this patient is homebound due to (Medicare only):

[ ]  Needs assistance for all activities [ ]  Confusion: unable to leave home alone [ ]  Residual weakness

[ ]  Severe shortness of breath [ ]  Requires maximum assistance / taxing effort to leave home

|  |  |  |  |
| --- | --- | --- | --- |
| Non-Physician Signature: |       | Date: |       /       /       |
| Physician Signature: |       | Date: |       /       /       |

\*\*physicians must co-sign non-physician initiated orders\*\*\*