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|  | **Corporate Office:**  410 Corporate Center Drive  Vandalia, OH 45377 | **North Office:**  423 N. Wayne Street  Piqua, OH 45356 | **South Office:**  445 Byers Road  Miamisburg, 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** |  |

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| 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\*\*\*