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HOME HEALTH SERVICES INC.

Referral Form

Patient Contact	Last:_____ First:_____ Middle:_____ Birth Date:_____ Gender: ☐ Male ☐ Female ☐ Other: _____ Marital Status:_____ Email:_____ Phone: _____ Type: ☐ Home ☐ Cellular ☐ Contact # (no patient phone) _____ Mailing Address:_____ City:_____ State:_____ Zip:_____ County:_____ ☐ Treatment Address same as Mailing Address (if no, add): _____ Emergency Contact: _____ Phone:_____ Power of Attorney (if applicable): _____ Phone: _____ Legal Guardian: _____ Phone: _____ Health Care Proxy: _____ Phone: _____ Invoked? ☐ Yes ☐ No	
Insurance	Primary Insurance:_____ Group # _____ Policy # _____ Patient's Relationship to PolicyHolder: _____	Secondary Insurance:_____ Group # _____ Policy # _____ Patient's Relationship to PolicyHolder: _____
Physician/ Practitioner	Check which physician is the certifying physician that has agreed to follow the patient for home health. Complete all physicians known. ☐ Referring Physician/Provider: _____ Phone:_____ ☐ Primary Care Physician: _____ Phone: _____ ☐ F2F Encounter Physician: _____ F2F Date: _____ ☐ F2F Encounter Requests Home Care Services ☐ Yes ☐ No Skill: _____ ☐ Has not occurred (must occur within 30 days of HH admission)	
Referral Information	Primary Diagnosis (including medical conditions): _____ _____ Secondary Diagnoses (List all that apply): _____ _____ Does the patient have any history of violence? ☐ Yes ☐ No	

Phone: (508) 827-7954 **Fax:** (800) 508-0614

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	Does the patient's diagnosis' support the need for Home Care Services: ☐ Yes ☐ No Does the skill requested support the diagnosis': ☐ Yes ☐ No Eval and Treat (check all that apply): ☐ SN ☐ OT ☐ Wound Care Additional Orders:_____ Wound Care Supplies: _____ _____ Referral Source has ordered Wound Care Supplies: ☐ Yes ☐ No Projected Frequency: _____ Specific Start of Care Date (if applicable): _____ Homebound Status: _____ Are all elements of Homebound Status present? ☐ Yes ☐ No
Admission/ Referral Source	☐ Institutional Admission (Patient is being admitted directly from):_____ Phone: _____ Fax: _____ Type: ☐ LTC ☐ SNF ☐ IPPS ☐ LTCH ☐ IRF ☐ Psychiatric Unit ☐Other:_____ ☐ Patient had an acute or post-acute stay in the last 14 days ☐ Community: _____ Phone: _____ Person Calling in Referral (name): _____ Phone: _____ Email: _____
Additional Information	FAX TO: 800-508-0614 **WITH COPIES OF:** PATIENT SUMMARY/DEMOGRAPHICS, LAST VISIT NOTE(S) OR DISCHARGE SUMMARY, MEDICATION LIST, ALLERGIES, A DIAGNOSIS LIST ALONG WITH ICD-10 CODES AND ANY UPCOMING APPOINTMENTS THE PATIENT MAY HAVE

Physician Signature:_____Date:_____