Home Health Referral

ABODE HOME HEALTH™

Patient Name: _____
Last First MI

Please attach demographics, history and physical and recent office notes: ☐ Attached

Please check all that apply:

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

Home Health Program
- ☐ CHF
- ☐ COPD
- ☐ Transitional Care

☐ *Hospice*

Specific Orders: _____

_____

_____

_____

1. Patient Name: _____ **2. Date of Birth** _____

3. Certification and Date of Face-to-Face Encounter. I certify that this patient is under my care and that I, or a nurse practitioner, clinical nurse specialist, or physician's assistant working with me, had a face-to-face encounter with this patient on: _____ (Date of Encounter)

4. Primary Diagnosis: _____

5. Certification of Medical Necessity. I certify that based on my clinical findings the following services are medically necessary home health services (check all that apply):

☐ **SN** ☐ **PT** ☐ **OT** ☐ **ST** ☐ **Home Health Aide** ☐ **MSW**

6. Certification of Homebound Status My clinical findings from this encounter support the patient is homebound due to: *(Must meet one of the two Criteria to qualify for home care.)*

☐ Because of illness or injury, or surgery, need the aid of supportive devices such as crutches, canes, wheelchairs, and walkers; the use of special transportation; or the assistance of another person to leave their residence.

☐ ***and/or***
Has a condition such that leaving his or her home is medically contraindicated.
Must meet this criteria to qualify.

☐ ***and/or***
A normal inability to leave home must exist and leaving home must require a considerable and taxing effort.

Physician Name: _____ **Physician Signature:** _____

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