VALERIAN
Home Health & Hospice

HOME HEALTH REFERRAL FORM

CMS may request medical information from Physicians. Please retain supporting documentation such as a d/c summary, labs, last office visit note, and medication profile in your medical record.

PATIENT

Please complete and fax the following information (or attached demographics/face sheet) and office visit note to ***888-983-1560***

Patient Name: _____ SS#: _____

Date of Birth: _____ ☐ M ☐ F Address: _____

Phone: _____ City, State, Zip: _____

Alternate Contact Name: _____ Referral Date: _____

Alternate Contact's Number: _____ ☐ Traditional Medicare ☐ Medicare Advantage Plan

Primary Care Physician: _____ Medicare # _____

Office Contact Name: Office Contact Number:

Diagnosis/Medical Condition *(List the diagnosis/medical conditions that are the primary reason the patient requires home health)*

_____

Skilled Services/Interventions *(Describe services the nurse or therapist will perform in the home, e.g. assess, teah, would care, gait training.)*

☐ Skilled Nursing For: _____ ☐ Occupational Therapy: _____

☐ Physical Therapy For: _____ ☐ Social Work: _____

☐ Speech Therapy For: _____ ☐ Home Health Aide: _____

Additional Orders: _____

CERTIFICATION FOR FACE TO FACE ENCOUNTER

I certify that this patient is under my care and that I, or a nurse practitioner or physician's assistant working with me or a physician who cared for the patient in an acute or post-acute facility had a face-to-face encounter related to the primary reason the patient requires home health that meets CMS requirements with this patient on:

Face to Face Encounter Date ____/____/____

Based on the above findings, I certify that this patient is confined to the home and needs intermittent skilled nursing, physical therapy, and/or speech therapy. The patient is under my care and I have initiated the establishment of the plan of care for home health.

Physician's Printed Name: _____

Physician's Signature _____ **Signature Date** ____/____/____

OPTIONAL PHYSICIAN DOUMENTATION

Clinical Findings (Signs and symptoms of medical condition exhibited by the patient during the encounter that support the need for all services listed above)

_____

_____

Homebound Status (Describe the clinical and/or physical findings and the functional limitations that result in the patient's normal inability to leave home.)

_____

_____