AAVI HOME HEALTH SERVICES

EXCELLENT CARE AT HOME

Home Health Referral Form

FACE SHEET

Patient Name: _____ Referral Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ DOB: ____ / ____ / ____ Gender: ☐ Male ☐ Female

Alternate Contact: _____ Contact Number: _____ Relationship: _____

Payer: ☐ Medicare ☐ Commercial / Medicare Advantage (Insurance phone number): _____

☐ Medicaid ☐ Other: _____ ☐ Secondary Plan: _____

HIC/ID#: _____ Policy #: _____ Group #: _____

Referring Primary Care Provider: _____ Phone: _____

Referring Facility: _____

Primary Care Provider for home health orders: _____ Phone: _____

Diagnoses: _____

LAST FACE TO FACE ENCOUNTER

Visit within past 90 days: ☐ Yes ☐ No FACE-TO-FACE ENCOUNTER DATE: _____

Along with this completed form, please attach the most recent document, clearly signed and dated by the Primary Care Provider, detailing the reason for recommending Home Health services along with this completed form. Examples of acceptable documents include: progress note, history and physical, or discharge summary. Thank you for trusting us with your patient, they'll be in good hands.

PRESCRIBED ORDERS FOR PATIENT CARE

Skilled Nursing: ☐ Medication management and teaching ☐ Disease management and teaching

☐ Observation and assessment of: _____

☐ Wound care (specify below or attach orders) location: _____ Frequency: _____

Clean w/: _____ Dress w/: _____

Clean w/: _____ Cover w/: _____

☐ Infusion (attach orders) ☐ Other (specify) _____

Physical Therapy: ☐ Coordination / Strength ☐ ROM exercise ☐ Endurance / balance ☐ Gait training Other: _____

Occupational Therapy: ☐ Safety at home ☐ DME use / need ☐ Ability to do ADLs Other: _____

Speech Therapy: ☐ Assessment and Evaluations / Aspiration prevention Other: _____

Medical Social Worker: ☐ Living situation / support system / community resources Other: _____

CHHA (certified home health aide): ☐ Provide / assist with personal care for incontinence Other: _____

Specialty Programs: ☐ Fall Prevention ☐ Chronic Disease Management Program (please circle): CHF | Diabetes | COPD

PRIMARY CARE PROVIDER'S SIGNATURE: _____ DATE: _____

HOMEBOUND STATUS

Homebound: Yes ☐ No ☐

Patient is confined because of illness, needs the aid of supportive devices such as crutches, canes, wheelchairs, and walkers; the use of specPatient has a normal inability to leave home.

Leaving home requires a considerable and taxing effort for the patient. Specify: patient requires assistance to leave home due to pain, instabill certify that the patient is confined to the home and needs intermittent skilled nursing care/therapy care.