

Referral to Home Health Order

Requesting Community/Office _____ Date _____
 Patient Name _____ DOB _____
 Address _____ City _____ Zip _____
 Primary Insurance _____ Policy Number _____
 Contact/POA Patient Other _____ Phone _____

Homebound Status

This Patient is limited by illness or injury and requires:

- Use of an assistive device
- Reliance on another person or transportation
- Considerable taxing effort
- Leaving the home is medically contraindicated due to: _____

This Patient has a normal inability to leave home, and leaving the home requires a considerable and taxing effort due to: _____

Attached Documentation

- Patient Demographics
- History and Physical
- Medication List
- Relevant Visit Note

* Certification requires that the overseeing PCP has seen the patient regarding current Home Health needs within the past 90 days.

Home Health Orders and Reasoning

- Nursing (RN)* _____
- Physical Therapy (PT)* _____
- Speech Language Pathology (SLP)* _____
- Occupational Therapy (OT) _____
- Home Health Aide (CNA) _____
- Social Work (MSW) _____

* Indicates a primary discipline. At least one of these is required to open service.

Primary Physician Name _____ Phone _____

Physician Signature _____ Date _____