CAREAGE
HOME HEALTH

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
- ☐ Advanced Directives
- ☐ Power of Attorney
- ☐ POLST

*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** _____

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